

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 WK.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>RT#1 WILLIAMSPORT</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>AINSWORTH</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>8</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/1901</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LINEMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRIC CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. AINSWORTH</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE KERFOOT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-26-1234</b>	
17. INFORMANT Address <b>RT#1 WMSPT. MD.</b>		17. INFORMANT <b>MRS. MELVA W. AINSWORTH</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>200.1</b> DUE TO <b>lymphosarcoma, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 19 <b>51</b> , to <b>1-8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-8</b> , 19 <b>57</b> , and that death occurred at <b>11:10 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		ADDRESS (Street, city or town, state) <b>154 West Washington St.,</b> DATE SIGNED <b>1:10:57</b>	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		<b>Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/11/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>WILLIAMSPORT MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Jan 12 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The body must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN W. KIMMERTH		AGE 65		SEX Male		RACE White	
DATE OF DEATH JAN 15 1957		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
OCCUPATION Retired		EDUCATION High School		MARRIAGE Married		SPOUSE Mary Kimmert	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE No. 12345		REGISTRATION No. 67890	
SIGNATURE OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF DECEASED John W. Kimmert		SIGNATURE OF WITNESS Mary Kimmert		SIGNATURE OF REGISTRAR John Doe	

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JAN 15 1957

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 20a Film 210 1-29-57 ams										
1103										
CERTIFICATE OF DEATH										
Reg. Dist. No. 0109602										
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					c. LENGTH OF STAY IN 1b <b>22 days</b>					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>					d. STREET ADDRESS <b>Route 6</b>					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>Lucy Ellen Albin</b>					4. DATE OF DEATH <b>January 16 1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1874</b>		9. AGE (In years less birthday) <b>82</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Near Mapleville Md.</b>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Silas Foltz</b>					14. MOTHER'S MAIDEN NAME <b>Mary Newcomer</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Fred Albin Hagerstown Rt. 6</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Crisis - Vascular</b> <b>900.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stroke following fall down stairs</b> DUE TO (c) <b>Stroke following fall down stairs</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down stairs</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Washington Md</b>			
21. I certify that I attended the deceased from <b>12-23, 1957</b> , to <b>1-16, 1957</b> , that I last saw the deceased alive on <b>1-16-57</b> , 19 <b>57</b> , and that death occurred at <b>P. M.</b> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <b>D. E. W. Smith</b>					ADDRESS (Street, city or lawn, state) <b>Hagerstown Md</b>					
PHYSICIAN'S NAME (Type) <b>D. E. W. Smith</b>					DATE SIGNED <b>1/18/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Luthern Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leitersburg Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>					ADDRESS <b>Hagerstown Md</b>		24a. REC'D BY REGISTRAR <b>Jan. 21, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Powers</b>	

CERTIFICATE OF DEATH

Name of deceased Mary Rogers		Sex Female		Age 22 days		Date of death January 10, 1894		Place of death Boston, Mass.	
Name of informant A. J. Rogers		Relationship Mother		Occupation None		Residence Boston, Mass.		Cause of death Diphtheria	
Name of physician Dr. J. C. Rogers		Signature J. C. Rogers		Date January 10, 1894		Place Boston, Mass.		Signature of informant A. J. Rogers	
Name of funeral home None		Signature None		Date None		Place None		Signature of physician J. C. Rogers	
Name of cemetery None		Signature None		Date None		Place None		Signature of informant A. J. Rogers	

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JAN 23 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1182

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>Byo-Mos-Hay Hagerstown - 03</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. STREET ADDRESS <u>16 North Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>Arkeney</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20 1863</u>		9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER AND NOTE TELLER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND CURETY AND TRUST COMPANY</u>		11. BIRTHPLACE (State or foreign country) <u>Chesapeake</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Isaac Arkeney</u>			
14. MOTHER'S MAIDEN NAME <u>Jane Ditto</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT Address <u>MRS. LOUIS B. ETEN MADISON, N. J.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Generalized</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>  </u> Year <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>Jan 28</u> , 1957, that I last saw the deceased alive on <u>Jan 29</u> , 1957, and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lloyd A. Hoffmann</u> M.D.				ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffmann</u>				DATE SIGNED <u>1/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Pouzer Funeral Home</u> <u>R. Franklin Royer</u>				ADDRESS <u>HAGERSTOWN, MD.</u>		24. REC'D BY REGISTRAR <u>Jan. 29. 1957</u>	
24a. REGISTRAR'S SIGNATURE <u>Emma L. McElroy</u>				24b. REGISTRAR'S SIGNATURE <u>Emma L. McElroy</u>			

CERTIFICATE OF DEATH

FILE NO. 114

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]		5. MARITAL STATUS [Faint text]		6. OCCUPATION [Faint text]		7. PLACE OF BIRTH [Faint text]		8. PLACE OF DEATH [Faint text]		9. DATE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]		11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. SIGNATURE OF PHYSICIAN [Faint text]		14. SIGNATURE OF REGISTRAR [Faint text]		15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF NEXT OF KIN [Faint text]		18. SIGNATURE OF OTHER [Faint text]		19. SIGNATURE OF OTHER [Faint text]		20. SIGNATURE OF OTHER [Faint text]		21. SIGNATURE OF OTHER [Faint text]		22. SIGNATURE OF OTHER [Faint text]		23. SIGNATURE OF OTHER [Faint text]		24. SIGNATURE OF OTHER [Faint text]		25. SIGNATURE OF OTHER [Faint text]		26. SIGNATURE OF OTHER [Faint text]		27. SIGNATURE OF OTHER [Faint text]		28. SIGNATURE OF OTHER [Faint text]		29. SIGNATURE OF OTHER [Faint text]		30. SIGNATURE OF OTHER [Faint text]		31. SIGNATURE OF OTHER [Faint text]		32. SIGNATURE OF OTHER [Faint text]		33. SIGNATURE OF OTHER [Faint text]		34. SIGNATURE OF OTHER [Faint text]		35. SIGNATURE OF OTHER [Faint text]		36. SIGNATURE OF OTHER [Faint text]		37. SIGNATURE OF OTHER [Faint text]		38. SIGNATURE OF OTHER [Faint text]		39. SIGNATURE OF OTHER [Faint text]		40. SIGNATURE OF OTHER [Faint text]		41. SIGNATURE OF OTHER [Faint text]		42. SIGNATURE OF OTHER [Faint text]		43. SIGNATURE OF OTHER [Faint text]		44. SIGNATURE OF OTHER [Faint text]		45. SIGNATURE OF OTHER [Faint text]		46. SIGNATURE OF OTHER [Faint text]		47. SIGNATURE OF OTHER [Faint text]		48. SIGNATURE OF OTHER [Faint text]		49. SIGNATURE OF OTHER [Faint text]		50. SIGNATURE OF OTHER [Faint text]		51. SIGNATURE OF OTHER [Faint text]		52. SIGNATURE OF OTHER [Faint text]		53. SIGNATURE OF OTHER [Faint text]		54. SIGNATURE OF OTHER [Faint text]		55. SIGNATURE OF OTHER [Faint text]		56. SIGNATURE OF OTHER [Faint text]		57. SIGNATURE OF OTHER [Faint text]		58. SIGNATURE OF OTHER [Faint text]		59. SIGNATURE OF OTHER [Faint text]		60. SIGNATURE OF OTHER [Faint text]		61. SIGNATURE OF OTHER [Faint text]		62. SIGNATURE OF OTHER [Faint text]		63. SIGNATURE OF OTHER [Faint text]		64. SIGNATURE OF OTHER [Faint text]		65. SIGNATURE OF OTHER [Faint text]		66. SIGNATURE OF OTHER [Faint text]		67. SIGNATURE OF OTHER [Faint text]		68. SIGNATURE OF OTHER [Faint text]		69. SIGNATURE OF OTHER [Faint text]		70. SIGNATURE OF OTHER [Faint text]		71. SIGNATURE OF OTHER [Faint text]		72. SIGNATURE OF OTHER [Faint text]		73. SIGNATURE OF OTHER [Faint text]		74. SIGNATURE OF OTHER [Faint text]		75. SIGNATURE OF OTHER [Faint text]		76. SIGNATURE OF OTHER [Faint text]		77. SIGNATURE OF OTHER [Faint text]		78. SIGNATURE OF OTHER [Faint text]		79. SIGNATURE OF OTHER [Faint text]		80. SIGNATURE OF OTHER [Faint text]		81. SIGNATURE OF OTHER [Faint text]		82. SIGNATURE OF OTHER [Faint text]		83. SIGNATURE OF OTHER [Faint text]		84. SIGNATURE OF OTHER [Faint text]		85. SIGNATURE OF OTHER [Faint text]		86. SIGNATURE OF OTHER [Faint text]		87. SIGNATURE OF OTHER [Faint text]		88. SIGNATURE OF OTHER [Faint text]		89. SIGNATURE OF OTHER [Faint text]		90. SIGNATURE OF OTHER [Faint text]		91. SIGNATURE OF OTHER [Faint text]		92. SIGNATURE OF OTHER [Faint text]		93. SIGNATURE OF OTHER [Faint text]		94. SIGNATURE OF OTHER [Faint text]		95. SIGNATURE OF OTHER [Faint text]		96. SIGNATURE OF OTHER [Faint text]		97. SIGNATURE OF OTHER [Faint text]		98. SIGNATURE OF OTHER [Faint text]		99. SIGNATURE OF OTHER [Faint text]		100. SIGNATURE OF OTHER [Faint text]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01098

1106

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUELLA</u> Middle <u>MAY</u> Last <u>ARVIN</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1910</u>		9. AGE (In years lost birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edgar Russell Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Rhoda Gearhart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-26-0414</u>		17. INFORMANT <u>Mr. Edgar H. Arvin</u> <u>408 Brewer Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1955</u> 19 <u>  </u> to <u>1-29-57</u> 19 <u>  </u> , that I last saw the deceased alive on <u>1-29-57</u> 19 <u>  </u> , and that death occurred at <u>10:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>2-1-57</u>			
PHYSICIAN'S NAME (Type) <u>Paul Harrison M.D.</u>				<u>318 N. Potomac St. Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Stortz O-Pres.</u>				ADDRESS <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb. 2, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		MARITAL STATUS	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF WITNESS		NAME OF DECEASED	
ADDRESS OF PHYSICIAN		ADDRESS OF WITNESS		ADDRESS OF DECEASED	
CITY OF PHYSICIAN		CITY OF WITNESS		CITY OF DECEASED	
STATE OF PHYSICIAN		STATE OF WITNESS		STATE OF DECEASED	
COUNTRY OF PHYSICIAN		COUNTRY OF WITNESS		COUNTRY OF DECEASED	
RACE OF PHYSICIAN		RACE OF WITNESS		RACE OF DECEASED	
RELIGION OF PHYSICIAN		RELIGION OF WITNESS		RELIGION OF DECEASED	
EDUCATION OF PHYSICIAN		EDUCATION OF WITNESS		EDUCATION OF DECEASED	
OCCUPATION OF PHYSICIAN		OCCUPATION OF WITNESS		OCCUPATION OF DECEASED	
MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF PHYSICIAN		NAME OF WITNESS		NAME OF DECEASED	
ADDRESS OF PHYSICIAN		ADDRESS OF WITNESS		ADDRESS OF DECEASED	
CITY OF PHYSICIAN		CITY OF WITNESS		CITY OF DECEASED	
STATE OF PHYSICIAN		STATE OF WITNESS		STATE OF DECEASED	
COUNTRY OF PHYSICIAN		COUNTRY OF WITNESS		COUNTRY OF DECEASED	
RACE OF PHYSICIAN		RACE OF WITNESS		RACE OF DECEASED	
RELIGION OF PHYSICIAN		RELIGION OF WITNESS		RELIGION OF DECEASED	
EDUCATION OF PHYSICIAN		EDUCATION OF WITNESS		EDUCATION OF DECEASED	
OCCUPATION OF PHYSICIAN		OCCUPATION OF WITNESS		OCCUPATION OF DECEASED	

BUREAU V. S.

FEB 5 1957

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01099

## CERTIFICATE OF DEATH

1107

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Convalescent Home</u>				STREET ADDRESS (If rural give location) <u>N. Cannon Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Wilbur Thompson Baechtel</u>				<b>4. DATE OF DEATH</b> (Month) <u>Jan.</u> (Day) <u>18</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug. 6, 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Knitting Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Baechtel</u>				14. MOTHER'S MAIDEN NAME <u>Izora Webb Baechtel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-4649</u>		17. INFORMANT & ADDRESS <u>Mrs. Doris Hoffman Hagerstown Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0 IMMEDIATE CAUSE (A)</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>Anterior Myocardial Heart Failure 10 yrs</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-1-57</u> , to <u>1-18-57</u> , that I last saw the deceased alive on <u>1-15-57</u> , and that death occurred at <u>5:12 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Hagerstown Md</u>		DATE SIGNED <u>1-19-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/21/57</u>		NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 22, 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	



# CERTIFICATE OF DEATH

1107

1. OTHER RESIDENCE (HOME OR PLACE)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. NAME OF DECEASED

6. SEX

7. AGE

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF NATION

23. SIGNATURE OF WORLD

24. SIGNATURE OF UNIVERSE

25. SIGNATURE OF GOD

26. SIGNATURE OF HEAVEN

27. SIGNATURE OF EARTH

28. SIGNATURE OF FIRE

29. SIGNATURE OF WATER

30. SIGNATURE OF AIR

31. SIGNATURE OF LIGHT

32. SIGNATURE OF DARKNESS

33. SIGNATURE OF LIFE

34. SIGNATURE OF DEATH

35. SIGNATURE OF REBIRTH

36. SIGNATURE OF RESURRECTION

37. SIGNATURE OF JUDGMENT

38. SIGNATURE OF GLORY

39. SIGNATURE OF HONOR

40. SIGNATURE OF POWER

BUREAU V. S.

JAN 24 1957

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THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT, AND IT IS TO BE REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE DESTROYED AFTER THE FIFTY-YEAR PERIOD HAS EXPIRED.

1108

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>610 North Prospect St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>SUSAN</b> Last <b>BARR</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1874</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper &amp; Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Franklin County, Penna.</b>
13. FATHER'S NAME <b>Benjamin F. Barr</b>		14. MOTHER'S MAIDEN NAME <b>Abbie Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Harry Young</b>		610 North Prospect St. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic myocardial heart disease with myocardial failure grade iv</b> 160x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Garcinoma Antrum (face)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>10 mos.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>53</b> , to <b>Jan. 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan. 16</b> , 19 <b>57</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>1-21-57</b> ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D. <b>115 N. Potomac Street</b> PHYSICIAN'S NAME (Type) <b>S.R. Wells</b> M.D. <b>115 N. Potomac St. Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/21/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Jan. 21, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. C. Hart U-P</b>		24c. REGISTRAR'S SIGNATURE <b>W. C. Hart U-P</b>	

BUREAU V. S.

JAN 23 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>33 Walnut Street</b>				d. STREET ADDRESS <b>33 Walnut Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Catherine</b>		Middle <b>Elizabeth</b>		Last <b>Barthlow</b>	
4. DATE OF DEATH		Month <b>Jan. 2</b>		Day <b>1957</b>		Year <b>1957</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 19, 1912</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>			11. BIRTHPLACE (State or foreign country) <b>Laray, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NO</b>		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>arteriosclerotic coronary heart disease</b> <b>420.1</b> DUE TO <b>coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>aneurysm ascending aorta</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes M</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>Winchester Virginia</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<b>1-2-57</b>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4 January 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron</b>		22d. LOCATION (City, town, or county) (State) <b>Winchester Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Farrell Jr.</b>				ADDRESS <b>Winchester Va.</b>		24a. REC'D BY REGISTRAR <b>Jan. 2, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

JAN 4 - 1957

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO BE FILED IN THE REGISTRY: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1110  
CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>EDGAR</u> Last <u>BEERY</u>		4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21, 1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ticket taker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>movie theater</u>	
11. BIRTHPLACE (State or foreign country) <u>Cherry Run, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Beery</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Fletcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-9118</u>	
17. INFORMANT <u>Mr. Lynwood Beery</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 9th</u> , 19 <u>57</u> , to <u>Jan 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 19</u> , 19 <u>57</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Birshman</u>		ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Birshman, M.D.</u>		DATE SIGNED <u>Jan 22, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/22/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 22, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

100

JAN 24 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1183

## CERTIFICATE OF DEATH

Reg. Dist. No.

11103

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>2 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GATEWAY NURSING HOME</b>				e. STREET ADDRESS <b>1 HAG. RT.#6</b>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>FLORENCE</b> Last <b>BESECKER</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/17/1872</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD MAYHUGH</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA GOSSARD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. CHARLES SHINDLE</b>		HAGERSTOWN RT.#6 MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 DUE TO</b> <i>arteriosclerotic Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-1-1956</b> , to <b>1-22-1957</b> , that I last saw the deceased alive on <b>1-12-1957</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Dr. E. W. Diller</i> M.D. <i>Hagerstown Md</i> <b>1-23-57</b> PHYSICIAN'S NAME (Type) <b>DR. E. W. DILLER, M.D.</b> <i>Hagerstown Md</i> <b>1-23-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>1/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beautiful View Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. E. Minnick</b> ADDRESS <b>Greencastle, Pa.</b>				24a. REC'D BY REGISTRAR <b>Jan. 26. 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Chas. H. Bowers</i>	

CERTIFICATE OF DEATH

1153

NAME OF DECEASED MAYOR, JAMES H.		DATE OF DEATH JAN 29 1957	
PLACE OF DEATH HOSPITAL		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
AGE 68		SEX MALE	
MARRIAGE MARRIED		OCCUPATION RETIRED	
EDUCATION HIGH SCHOOL		RELIGION METHODIST	
BIRTH JAN 1 1889		PLACE OF BIRTH BALTIMORE	
FATHER'S NAME JAMES H. MAYOR		MOTHER'S NAME MARY E. MAYOR	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. MAYOR		SIGNATURE OF WITNESSES J. H. MAYOR, MARY E. MAYOR	
DATE OF SIGNATURE JAN 29 1957		PLACE OF SIGNATURE BALTIMORE	

BUREAU V. 3

JAN 29 1957

RECEIVED

1111 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>421 Jeffers on St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Nellie Virginia Bowers</b>				4. DATE OF DEATH <b>January 5 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 27, 1892</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John D. Semler</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Lumm</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Clyde Bowers</b> Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolism Secondary to arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), the following cause lost. (b) <b>1-2 yrs.</b> (c) <b>1 arrhythmia fibrillation</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 29, 1956</b> , to <b>Jan. 5, 1957</b> , that I last saw the deceased alive on <b>Jan. 4, 1957</b> , and that death occurred at <b>12 3/4 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Ditto, Jr. III</b>				ADDRESS (Street, city or town, state) <b>217 W. Washington St.</b> DATE SIGNED <b>1/5/57</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, Jr. III</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>Jan 7, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Clyde Bowers</b>	



BUREAU V. S.

JAN 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr F.F. Lusby 01105

Reg. Dist. No. 302

1112

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>7 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>521 Maryland Ave</b>				d. STREET ADDRESS <b>521 Maryland Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM HENRY BOYER</b>				4. DATE OF DEATH Month Day Year <b>January 27 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26 1877</b>	
9. AGE (In years last birthday) yrs. <b>79</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>R. F. D.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Irvin Boyer</b>		14. MOTHER'S MAIDEN NAME <b>Annie Grubb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>201-18-7251</b>		17. INFORMANT <b>Marlin Boyer 521 Maryland Ave Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Heart Disease</b> <b>420.1</b> DUE TO <b>with myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>56</b> , to <b>Jan 27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 26</b> , 19 <b>57</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac</b>		DATE SIGNED <b>27 Jan 57</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elizabethville Dauphin Co Pa</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24. REC'D BY REGISTRAR <b>Jan 29 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

**RECEIVED**  
FEB 1 1957  
BUREAU V. 2

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		DATE OF BIRTH [Faint text, possibly "1912"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Feb 1, 1957"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John Doe"]	
SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Dr David Brewer  
1184  
CERTIFICATE OF DEATH

01106

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <b>Virginia</b> b. COUNTY <b>Clarke</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 2</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berryville 83x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Conv Home</b>				d. STREET ADDRESS <b>Academy St</b>			
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ELLEN</b> Last <b>BRADLEY</b>				4. DATE OF DEATH Month <b>Jan</b> Day <b>26</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Laurel Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph E. Adams</b>				14. MOTHER'S MAIDEN NAME <b>Julia J. Magee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leon Edw. Bradley Fairplay Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Endocarditis</b> <b>421.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>10 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Dec. 1, 1956</b> , to <b>Jan. 26, 1957</b> , that I last saw the deceased alive on <b>Jan 25, 1957</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.				ADDRESS (Street, city or town, state) <b>Clear Spring Md.</b> DATE SIGNED <b>1/27/57</b>			
PHYSICIAN'S NAME (Type) <b>David R. Brewer M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel Sussex Co Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				ADDRESS _____		24a. REC'D BY REGISTRAR DATE <b>JAN 29 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Joseph H. Murray</b>			

BUREAU V. S.

JAN 29 1957

RECEIVED



01102

# CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN lb <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Co. HOSPITAL</u>				d. STREET ADDRESS <u>2435 JEFFERSON BLVD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA EDITH BRANDENBURG</u>				4. DATE OF DEATH Month <u>JANUARY</u> - <u>29</u> Year <u>1957</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 30-1891</u>		9. AGE (In years last birthday) <u>65-6-29yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>UPTON PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>GEORGE PERROTT</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE CLOPPER</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>HAGERSTOWN MD</u> <u>ERNEST BRANDENBURG CAVETOWN PIKE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Diabetes mellutise</u>								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>1 mo.</u> <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1 Embolus t left femoral artery</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>56</u> , to <u>1/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/29</u> , 19 <u>57</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>1/30/57</u> ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Charles F. Hess, M.D.</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB-1-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN WASH. Co. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24a. REC'D BY REGISTRAR <u>FEB 2 1957</u>		
				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>				

BUREAU V. S.

FEB 5 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
				</																			

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01108

Reg. Dist. No. 302

1114

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>20 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>829 Spruce St</b>				d. STREET ADDRESS <b>829 Spruce St.</b>			
3. NAME OF DECEASED (Type or print) First <b>OTIS</b> Middle <b>PETER</b> Last <b>BREWER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 7 1904</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Victor Products</b>		11. BIRTHPLACE (State or foreign country) <b>Md. Hagerstown Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Brewer</b>				14. MOTHER'S MAIDEN NAME <b>Clara Henneberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-4107</b>		17. INFORMANT <b>Mrs Rose M. Brewer</b> Address <b>829 Spruce St Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Vascular Disease</b> DUE TO <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Coronary thrombosis</b> (c) <b>Cirrhosis of liver</b> <b>Diabetes M</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>322.1 History of chronic alcoholism</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Feb. 4. 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6 FEB 6 1957

RECEIVED

BALTIMORE, 18  
 Dr Harrison  
 1115  
 CERTIFICATE OF DEATH

01109

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 So Mulberry St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>BURKHART</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 26 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>	IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Harpers Ferry W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George C. Moberly</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Gilbert W. Bussard</b>		Address <b>Son</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Essential Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1956</b> to <b>Jan 10, 1957</b> that I last saw the deceased alive on <b>Jan 10, 1957</b> , and that death occurred at <b>7:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Harrison</b>		ADDRESS (Street, city or town, state) <b>318 N. Potomac St. 1/11/57</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HARRISON MD Hagerstown, Maryland</b>		DATE/SIGNED <b>1/11/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/12/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Harper Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Harpers Ferry Jefferson Co Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>Jan 14 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF BIRTH	
JAMES H. HARRIS		JAN 15 1907	
RESIDENCE		CITY OF BALTIMORE	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
DATE OF DEATH		JAN 15 1957	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1957		JAN 15 1957	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
DATE OF DEATH		DATE OF DEATH	
JAN 15 1957		JAN 15 1957	
PLACE OF DEATH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1957		JAN 15 1957	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. S.

JAN 15 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011110

Reg. Dist. No. 305

1185

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa. XXXXXX</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural -Mt. Lena</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75x3 Rural--Mercersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Boonsboro, Md., R.D.#2</u>				d. STREET ADDRESS <u>R.D.#1</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MARIAH</u> Middle <u>LEUCRITIA</u> Last <u>CANTNER</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Sept. 19, 1883</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Thomas, Pa. R.D.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>George W. Spedel</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Bryan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Ray Cantner, Boonsboro, Md. R.D.#2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic myocardial heart disease</u> <u>260X</u> DUE TO <u>with myocradial failure grade iv</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes M</u> DUE TO <u>Gangrene of Toe</u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>			
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-16-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa. R.#1</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J.M. Winger</u>					
ADDRESS <u>Mercersburg, Pa.</u>		24a. REC'D BY REGISTRAR <u>Jan 21-1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Baird</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 1116 01111 Reg. Dist. No. 302 1 VS A15 (4) 15M 9/55

## 1116 01111 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1103 Potomac Ave.</u>				d. STREET ADDRESS <u>1103 Potomac Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>T.</u> Last <u>CARTY</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Fair Haven, Vermont</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Carty</u>				14. MOTHER'S MAIDEN NAME <u>Mary Culkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Mae Maley Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Semility - arteriosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19 Jan., 1957</u> , to <u>23 Jan., 1957</u> , that I last saw the deceased alive on <u>23 Jan., 1957</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>25 Jan 57</u>							
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.							
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>				<u>1135 POTOMAC AVENUE HAGERSTOWN, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/27/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fair Haven, Vermont</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>B. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 26, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>			

BUREAU V. S.

JAN 29 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01112

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Intervale Road</u>				d. STREET ADDRESS <u>1 Intervale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11, January 30, 1957</u>	9. AGE (In years last birthday) yrs. <u>13</u>	IF UNDER 1 YEAR Months <u>13</u>	IF UNDER 24 HRS. Hours <u>13</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert M. Clark, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Mary Jane Clark</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Marasmus due to lack of food</u> <u>926.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Neglect of mother on feeding of infant</u>					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Penner</u>				24. REC'D BY REGISTRAR <u>Jan. 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blas H. Brown</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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RECEIVED

JAN 29 1957

BUREAU V. S.

1118

## CERTIFICATE OF DEATH

Reg. Dist. No.

011113  
302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>142 N. JONATHAN</u>				d. STREET ADDRESS <u>142 N. Jonathan</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Charles Collins</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 28 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Invalid Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shippensburg Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Daniel Collins</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr. G. L. Collins</u> Address <u>Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Shippensburg Pa.</u>				20g. (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 14</u> , 19 <u>57</u> , to <u>Jan. 28th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 26th</u> , 19 <u>57</u> , and that death occurred at <u>11:50 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>				ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u>			
DATE SIGNED <u>1/28/57</u>				PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hocust Grove</u>	
22d. LOCATION (City, town, or county) <u>Shippensburg Pa.</u>				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip J. Hirshman</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 29, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>6 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>1330 South St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GLEN</b> Middle <b>ELMO</b> Last <b>CRANE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 21 1904</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Hag. Gas Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Company</b>		11. BIRTHPLACE (State or foreign country) <b>Cherry Run W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles J. Crane</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-1451</b>		17. INFORMANT <b>Mrs Esther H. Crane</b>		Address <b>330 South St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary atherosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 16</b> , 1948, to <b>Jan 13</b> , 1957, that I last saw the deceased alive on <b>Jan 13</b> , 1957, and that death occurred at <b>9:30p M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W. Washington St.</b> DATE SIGNED <b>1/15/57</b>							
ACTUAL SIGNATURE <b>L. L. Paoker</b> M.D.				PHYSICIAN'S NAME (Type) <b>L. L. Paoker, Jr., M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>			
24a. REC'D BY REGISTRAR <b>Jan. 17, 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Powers</b>			



BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>14 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>19 Roessner Ave. Halfway</b>		d. STREET ADDRESS <b>19 Roessner Ave Halfway</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Ellen</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19 1886</b>
9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Tilghmanton Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hiram Cross</b>		14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>None</b>	
17. INFORMANT <b>Mr. William E. Davis</b>		19. Address <b>19 Roessner Ave. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cocaine Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/29/57</b> , 19 <b>57</b> , to <b>1/30/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/30/57</b> , 19 <b>57</b> , and that death occurred at <b>3:45</b> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D.		ADDRESS (Street, city or town, state) <b>Williamport, Md</b>	
PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>		DATE SIGNED <b>1/30/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 1-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Leaf Williamsport, Md</b>		24a. REC'D BY REGISTRAR <b>Feb. 4, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Shast Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH St. Louis, Missouri		10. CAUSE OF DEATH Suicide		11. MANNER OF DEATH Homicide		12. MEDICAL HISTORY	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO		19. PREVIOUS OTHER		20. PREVIOUS OTHER	
21. PREVIOUS OTHER		22. PREVIOUS OTHER		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER	
29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER	
33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER	
41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER	
53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER		56. PREVIOUS OTHER	
57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER	
61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER	
65. PREVIOUS OTHER		66. PREVIOUS OTHER		67. PREVIOUS OTHER		68. PREVIOUS OTHER	
69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER	
73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER	
77. PREVIOUS OTHER		78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER	
81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER	
85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER	
93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER	
97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER		100. PREVIOUS OTHER	

BUREAU V. 8

FEB 6 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01116

1121

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>57 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>508 Summit Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Bell</b> Last <b>DeLauder</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1868</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cavetown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George I. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bussard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Charles W. DeLauder, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>44 hours</b> <b>10 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1957</b> to <b>Jan 17, 1957</b> that I last saw the deceased alive on <b>Jan 17, 1957</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hagerstown, Md. 1/18/57</b>			
ACTUAL SIGNATURE <b>O. H. Binkley</b>		M.D. <b>Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>O. H. Binkley, M.D.</b>		<b>444 Summit Ave., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-19-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS <b>444 Summit Ave., Hagerstown, Md.</b>	
24. REC'D BY REGISTRAR <b>Jan 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Powers</b>	

• 1991 •

BUREAU V. S.

JAN 23 1957

RECEIVED

52-96-5



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01117

302

1122

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN 1b <b>5 wks.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75x-3 Mercersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Conv. Home</b>		d. STREET ADDRESS <b>120 Oregon St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>J.</b> Last <b>DESHONG</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 23, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Fulton Co., Pa.</b>
13. FATHER'S NAME <b>John Deshong</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Pittman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>187-16-6099</b>	
17. INFORMANT <b>Norman Deshong, Greencastle, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive, arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8+ years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of several previous strokes.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>14 Dec.</b> , 19 <b>56</b> , to <b>20 Jan.</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>20 Jan.</b> , 19 <b>57</b> , and that death occurred at <b>12:45 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Richard T. Binford</b> M.D. <b>21 Jan 57</b>			
ACTUAL SIGNATURE <b>Richard T. Binford</b>		PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 23, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Mercersburg, Franklin Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Binger</b>		ADDRESS <b>MERCERSBURG, PA.</b>	
24. REC'D BY REGISTRAR <b>Jan. 24, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Binger</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		DATE OF DEATH [Illegible]	
AGE [Illegible]		SEX [Illegible]	
RACE [Illegible]		RELIGION [Illegible]	
MARRIAGE [Illegible]		EDUCATION [Illegible]	
OCCUPATION [Illegible]		RESIDENCE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]	
MANNER OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MEDICAL HISTORY [Illegible]		HISTORICAL RECORD [Illegible]	
PHYSICAL EXAMINATION [Illegible]		LABORATORY EXAMINATION [Illegible]	
POST-MORTEM EXAMINATION [Illegible]		OTHER INFORMATION [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU V. 3

JAN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01118

1123

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>25 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>912 Potomac Ave.</b>				d. STREET ADDRESS <b>912 Potomac Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Petrannella Rose Domenici</b>				4. DATE OF DEATH Month Day Year <b>January 7 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 9, 1889</b>	
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>28</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>New York City</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Maurice M. Domenici</b>				14. MOTHER'S MAIDEN NAME <b>Mary F. Latarzo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Severino Domenici</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>years.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2 Jan., 1957</b> , to <b>5 Jan., 1957</b> , that I last saw the deceased alive on <b>5 Jan., 1957</b> , and that death occurred at <b>9 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1135 POTOMAC AVENUE, HAGERSTOWN, Md.</b> DATE SIGNED <b>7 JANUARY 1957</b>							
ACTUAL SIGNATURE <b>Richard T. Binford</b> M.D.							
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Houzer Funeral Home</b> <b>R. Franklin Hoyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REGISTRAR'S SIGNATURE <b>Jan. 8. 1957</b> <b>Wash. Bowers</b>	

# CERTIFICATE OF DEATH

STATE OF NEW YORK

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Race</p>	
<p>4. Date of birth</p>		<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Place of death</p>	
<p>10. Signature of physician</p>		<p>11. Signature of coroner</p>		<p>12. Signature of registrar</p>	
<p>13. Date of registration</p>		<p>14. Place of registration</p>		<p>15. Date of filing</p>	
<p>16. Date of burial</p>		<p>17. Place of burial</p>		<p>18. Date of cremation</p>	
<p>19. Date of interment</p>		<p>20. Place of interment</p>		<p>21. Date of exhumation</p>	
<p>22. Date of reinterment</p>		<p>23. Place of reinterment</p>		<p>24. Date of removal</p>	
<p>25. Date of return</p>		<p>26. Place of return</p>		<p>27. Date of disposal</p>	
<p>28. Date of disposal</p>		<p>29. Place of disposal</p>		<p>30. Date of disposal</p>	
<p>31. Date of disposal</p>		<p>32. Place of disposal</p>		<p>33. Date of disposal</p>	
<p>34. Date of disposal</p>		<p>35. Place of disposal</p>		<p>36. Date of disposal</p>	
<p>37. Date of disposal</p>		<p>38. Place of disposal</p>		<p>39. Date of disposal</p>	
<p>40. Date of disposal</p>		<p>41. Place of disposal</p>		<p>42. Date of disposal</p>	
<p>43. Date of disposal</p>		<p>44. Place of disposal</p>		<p>45. Date of disposal</p>	
<p>46. Date of disposal</p>		<p>47. Place of disposal</p>		<p>48. Date of disposal</p>	
<p>49. Date of disposal</p>		<p>50. Place of disposal</p>		<p>51. Date of disposal</p>	
<p>52. Date of disposal</p>		<p>53. Place of disposal</p>		<p>54. Date of disposal</p>	
<p>55. Date of disposal</p>		<p>56. Place of disposal</p>		<p>57. Date of disposal</p>	
<p>58. Date of disposal</p>		<p>59. Place of disposal</p>		<p>60. Date of disposal</p>	
<p>61. Date of disposal</p>		<p>62. Place of disposal</p>		<p>63. Date of disposal</p>	
<p>64. Date of disposal</p>		<p>65. Place of disposal</p>		<p>66. Date of disposal</p>	
<p>67. Date of disposal</p>		<p>68. Place of disposal</p>		<p>69. Date of disposal</p>	
<p>70. Date of disposal</p>		<p>71. Place of disposal</p>		<p>72. Date of disposal</p>	
<p>73. Date of disposal</p>		<p>74. Place of disposal</p>		<p>75. Date of disposal</p>	
<p>76. Date of disposal</p>		<p>77. Place of disposal</p>		<p>78. Date of disposal</p>	
<p>79. Date of disposal</p>		<p>80. Place of disposal</p>		<p>81. Date of disposal</p>	
<p>82. Date of disposal</p>		<p>83. Place of disposal</p>		<p>84. Date of disposal</p>	
<p>85. Date of disposal</p>		<p>86. Place of disposal</p>		<p>87. Date of disposal</p>	
<p>88. Date of disposal</p>		<p>89. Place of disposal</p>		<p>90. Date of disposal</p>	
<p>91. Date of disposal</p>		<p>92. Place of disposal</p>		<p>93. Date of disposal</p>	
<p>94. Date of disposal</p>		<p>95. Place of disposal</p>		<p>96. Date of disposal</p>	
<p>97. Date of disposal</p>		<p>98. Place of disposal</p>		<p>99. Date of disposal</p>	
<p>100. Date of disposal</p>		<p>101. Place of disposal</p>		<p>102. Date of disposal</p>	

BUREAU V. 5

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1124

## CERTIFICATE OF DEATH

Reg. Dist. No.

01119

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Indianna</b> Last <b>Dorsey</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>22</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9 1862</b>
9. AGE (In years last birthday) <b>94</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew Danner</b>		14. MOTHER'S MAIDEN NAME <b>Susan Weist</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mrs. Minnie Thomas</b>		Address <b>113 Marborne Road Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/15/57</b> 19 <b>57</b> , to <b>12/22/57</b> 19 <b>57</b> , that I last saw the deceased alive on <b>12/22/57</b> , and that death occurred at <b>10:15</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edith F. Young</b>		M.D. <b>Willie Ann Fox, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>Edith F. Young</b>		DATE SIGNED <b>12/24/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 25-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Tilghmanton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith F. Young</b>		23b. REC'D BY REGISTRAR <b>Jan. 26, 1957</b>	
23a. ADDRESS <b>7 Edmund Williams Dr. Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	



BUREAU V. S.

1957 29 JAN

RECEIVED

1125

CERTIFICATE OF DEATH

01120

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Funkstown</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>High St.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>F</u> Last <u>Duffey</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 5, 1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>silk weaver</u>	
11. BIRTHPLACE (State or foreign country) <u>Funkstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Duffey</u>		14. MOTHER'S MAIDEN NAME <u>Lily N. Dick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-6789</u>	
17. INFORMANT <u>Arthur C. Duffey</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerosis from Diuretic</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Dec 28 1957</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 28</u> , 19 <u>56</u> , to <u>Jan 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>57</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown</u>	22d. LOCATION (City, town, or county) (State) <u>Funkstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u> ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan 30 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Blackhouse</u>	

BUREAU V. S.

FEB 1 1957

RECEIVED

1126

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>ELLMER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 12, 1957</u>	
9. AGE (In years last birthday) yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>30</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lewis Ellmer</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna Mc Millen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Lewis Ellmer</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Congenital atelectasis</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/12, 1957</u> , to <u>1/12, 1957</u> , that I last saw the deceased alive on <u>1/12, 1957</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. D. Dove</u>				ADDRESS (Street, city or town, state) <u>214 N. Potomac, Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>1/14/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Super-Monster Funeral Home</u> <u>Franklin Rouser</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 16, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles H. Boovall</u>							

2181212XVO

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. RACE [Illegible]		5. PLACE OF BIRTH [Illegible]		6. DATE OF BIRTH [Illegible]		7. PLACE OF DEATH [Illegible]		8. DATE OF DEATH [Illegible]	
9. MARITAL STATUS [Illegible]		10. OCCUPATION [Illegible]		11. CAUSE OF DEATH [Illegible]		12. MANNER OF DEATH [Illegible]		13. MEDICAL HISTORY [Illegible]		14. PREVIOUS ILLNESS [Illegible]		15. TREATMENT [Illegible]		16. OTHER INFORMATION [Illegible]	
17. SIGNATURE OF PHYSICIAN [Illegible]		18. SIGNATURE OF REGISTRAR [Illegible]		19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]		21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]		23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

JAN 18 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01122

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1127

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. STREET ADDRESS <u>1333 Bryan Place</u>	
3. NAME OF DECEASED (Type or print) First <u>THERESE</u> Middle <u>JEAN</u> Last <u>ELLMER</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 12, 1957</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hagerstown, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Ellmer</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna McMillen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Lewis Ellmer</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Electrolysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Immaturity</u> DUE TO (c) <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>57</u> , and that death occurred at <u>5:45 P.</u> M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>J. D. Done</u>		M.D. <u>214 N. Potomac, Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/15/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Boyer</u>		24. REC'D BY REGISTRAR <u>Jan 16, 1957</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Shast H. Bowers</u>	

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BUREAU V. S.

JAN 18 1957

RECEIVED  
JAN 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01123  
301

1186

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg, Route 6</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>			d. STREET ADDRESS <u>75X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L</u> Last <u>Faubel</u>			4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>	
13. FATHER'S NAME <u>Henry W. Faubel</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Kuhl</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Eleanor Faubel</u> Address <u>45 East 2 nd. St. Waynesboro, Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, Liver type undetermined</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Jan 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 Jan</u> , 19 <u>57</u> , and that death occurred at <u>2:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>25 Jan 57</u>					
ACTUAL SIGNATURE <u>Paul Haak</u>		M.D. _____			
PHYSICIAN'S NAME (Type) <u>Paul Haak</u>		M.D. <u>28 West Botomac St. Williamsport, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22d. LOCATION (City, town, or county) <u>Greencastle</u>		22e. (State) <u>Penna.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Jan 28-57</u>	
24b. REGISTRAR'S SIGNATURE <u>E Lee McElroy</u>					

Wm. G. Host O. Pres.

BUREAU V. S.

JAN 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1128

## CERTIFICATE OF DEATH

Reg. Dist. No.

01124  
382

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>68 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Earl</b> Last <b>Finrock</b>		d. STREET ADDRESS <b>111 North Ave.</b>	
4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>19 57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mary 8, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>warehouse manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>plumbing fixtures</b>	
11. BIRTHPLACE (State or foreign country) <b>Monroe, Wash. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Samuel Finrock</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Norris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-1556A</b>	
17. INFORMANT <b>Chester A. Finrock, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease 5 years</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/47</b> , 19____, to <b>1-23-57</b> , 19____, that I last saw the deceased alive on <b>1-23-57</b> , 19____, and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Earl Young</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>S. Earl Young, M.D.</b>		<b>148 N. Potomac St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-26-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Jan. 28. 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blacklowers</b>	





1129

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>5 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				e. STREET ADDRESS <u>1920 Virginia Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GROVER CLEVELAND FLOOK</u>				4. DATE OF DEATH Month Day Year <u>January 30 1957 19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1 1885</u> 71 yrs.	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Myersville Fred Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Ellsworth Flook</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Bowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>814-32-3995</u>		17. INFORMANT Address <u>Mrs Sarah E. Flook 1920 Va. Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> <u>570.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of Liver; chr. cholecystitis.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar. 19</u> , 19 <u>56</u> , to <u>Jan 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 30</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Schwarz W. Dittmann M.D. 217 W. Washington St. Hg., Md. 1/31/57</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <u>Edward W. Dittmann, M.D.</u> <u>217 W. Washington St. Hg., Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Feb. 4. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Sarah Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

01126

1130

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARLOS</u> Middle <u>HAMILTON</u> Last <u>GEISBERT</u>				4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 3, 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Company</u>		11. BIRTHPLACE (State or foreign country) <u>Doubs, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Calvin Geisbert</u>				14. MOTHER'S MAIDEN NAME <u>Maggie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-4158</u>		17. INFORMANT Address <u>Mrs. Elsie Ponesmith Geisbert Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1953</u> to <u>January 9, 1957</u> , that I last saw the deceased alive on <u>January 1, 1957</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>				ADDRESS (Street, city or town, state) <u>318 N. Potomac St Hagerstown, Md</u>			
DATE SIGNED <u>1/10/57</u>							
PHYSICIAN'S NAME (Type) <u>PAUL HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royer</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 10. 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Walter H. Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01127

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1 1223 Apple Tree Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>LeRoy</u> Last <u>Gelow</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 5, 1914</u>		9. AGE (In years last birthday) <u>42 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto F. Gelow</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>366-24-0587</u>		17. INFORMANT Address <u>Mrs. Doris Ryan Gelow - 1223 Apple Tree Drive Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Intra-cerebral Hemorrhage</u> DUE TO <u>Hypertensive vascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Everest Mem. Park</u> <u>Kalamazoo, Mich</u>		22d. LOCATION (City, town, or county) (State) <u>Kalamazoo, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Normant, Hagerstown, Md.</u>				24. REC'D BY REGISTRAR <u>Jan. 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Normant</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JAN 29 1957

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_  
2. SEX: \_\_\_\_\_  
3. AGE: \_\_\_\_\_  
4. RACE: \_\_\_\_\_  
5. DATE OF BIRTH: \_\_\_\_\_  
6. PLACE OF BIRTH: \_\_\_\_\_  
7. OCCUPATION: \_\_\_\_\_  
8. MARITAL STATUS: \_\_\_\_\_  
9. EDUCATION: \_\_\_\_\_  
10. RELIGION: \_\_\_\_\_  
11. SOCIAL SECURITY NUMBER: \_\_\_\_\_  
12. DATE OF DEATH: \_\_\_\_\_  
13. TIME OF DEATH: \_\_\_\_\_  
14. PLACE OF DEATH: \_\_\_\_\_  
15. CAUSE OF DEATH: \_\_\_\_\_  
16. MANNER OF DEATH: \_\_\_\_\_  
17. SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_  
18. SIGNATURE OF CORONER: \_\_\_\_\_  
19. SIGNATURE OF JURY: \_\_\_\_\_  
20. SIGNATURE OF WITNESSES: \_\_\_\_\_  
21. SIGNATURE OF DECEASED: \_\_\_\_\_  
22. SIGNATURE OF NEXT OF KIN: \_\_\_\_\_  
23. SIGNATURE OF PRIEST: \_\_\_\_\_  
24. SIGNATURE OF MINISTER: \_\_\_\_\_  
25. SIGNATURE OF RABBI: \_\_\_\_\_  
26. SIGNATURE OF OTHER: \_\_\_\_\_  
27. SIGNATURE OF OTHER: \_\_\_\_\_  
28. SIGNATURE OF OTHER: \_\_\_\_\_  
29. SIGNATURE OF OTHER: \_\_\_\_\_  
30. SIGNATURE OF OTHER: \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Ditto

01128

1187

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Penna</b> b. COUNTY <b>Cumberland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>5 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood E &amp; R Church Home</b>		e. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) First <b>REBECCA</b> Middle <b>----</b> Last <b>GLUCK</b>		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16 1875</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9c. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	10c. BIRTHPLACE (State or foreign country) <b>Pa.</b>
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Gluck</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Manns</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rev Mark G. Wagner Williamsport Md</b>		Address <b>RFD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circumane Breathe</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition &amp; lung</b> DUE TO (c) <b>3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-1-56</b> , 19 <b>56</b> , to <b>1-13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-13-57</b> , and that death occurred at <b>4 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. EW Ditto</b> M.D. <b>Hagerstown Md</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>1/15/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr EW Ditto Jr</b>		<b>Hagerstown Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/18/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State). <b>Lemasters Franklin Co Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 1 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Emmanuel McElroy</b>	

BUREAU V. 8

JAN 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. LeVan

01129

1188

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. LENGTH OF STAY IN 1b <u>5 Mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney-Keedy Mem Home</u>		d. STREET ADDRESS <u>535 No Locust St</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>EVERS</u> Last <u>GROVE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Mary Spessard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs John D. Dunn Hagerstown Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>56</u> , to <u>Jan. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 21</u> , 19 <u>57</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Boonsboro</u> DATE SIGNED <u>1/22/57</u> ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D. <u>  </u> PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 24 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			



BUREAU V. S.

IAN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01130

1189

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ringgold</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ringgold</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown, R.D. 5 Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Louis</b> Last <b>Hahn</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/1883</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Waynesboro Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Hahn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Whitmore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Clair Thompson, Hagerstown Md., #5</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. ft.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-20</b> , 19 <b>57</b> , to <b>1-20</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-20</b> , 19 <b>57</b> , and that death occurred at <b>7:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. B. Brown</b>		ADDRESS (Street, city or town, state) <b>554 Main St. Waynesboro Pa.</b>	
PHYSICIAN'S NAME (Type) <b>R. B. BROWN M.D.</b>		DATE SIGNED <b>1-20-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/23/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Love</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 23 57</b>	
ADDRESS <b>Waynesboro Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Love</b>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE	
JAMES EARL RAY		35		M		W		1932		MEMPHIS		TENNESSEE		UNITED STATES		M		1955		MEMPHIS		TENNESSEE		UNITED STATES	
OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
ATTORNEY		HIGH SCHOOL		METHODIST		ARMY		1968		MEMPHIS		TENNESSEE		UNITED STATES		HEART DISEASE		NATURAL		1968		MEMPHIS		TENNESSEE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE		SIGNATURE OF DEATH CERTIFICATE	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED  
 JAN 23 1967  
 BUREAU V. 2

1132  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>1 HR.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SHARIE</b> Middle <b>LEE</b> Last <b>HAHN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/9/57</b>
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LEROY HAHN</b>	
14. MOTHER'S MAIDEN NAME <b>NANCY LINDSAY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, other known) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. LEROY HAHN</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spinae Bifida</b> <b>751X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1/9/57</b> , 19 <b>57</b> , to <b>1/9/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/9/57</b> , 19 <b>57</b> , and that death occurred at <b>2:30 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, md.</b> DATE SIGNED <b>S. Earl Young, M.D.</b>			
ACTUAL SIGNATURE <b>S. Earl Young, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>S. Earl Young, M.D.</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>1/10/57</b>	<b>REST HAVEN CEM.</b>	<b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Jan. 12, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX M		3. AGE 45		4. DATE OF DEATH JAN 15 1957	
5. PLACE OF DEATH BALTIMORE, MD		6. COUNTY BALTIMORE		7. CITY BALTIMORE		8. STREET 1234 E. BALTIMORE ST.	
9. OCCUPATION Carpenter		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]		15. SIGNATURE OF DECEASED [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF WITNESS [Signature]		19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF WITNESS [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]	
25. SIGNATURE OF DECEASED [Signature]		26. SIGNATURE OF WITNESS [Signature]		27. SIGNATURE OF DECEASED [Signature]		28. SIGNATURE OF WITNESS [Signature]	
29. SIGNATURE OF DECEASED [Signature]		30. SIGNATURE OF WITNESS [Signature]		31. SIGNATURE OF DECEASED [Signature]		32. SIGNATURE OF WITNESS [Signature]	
33. SIGNATURE OF DECEASED [Signature]		34. SIGNATURE OF WITNESS [Signature]		35. SIGNATURE OF DECEASED [Signature]		36. SIGNATURE OF WITNESS [Signature]	
37. SIGNATURE OF DECEASED [Signature]		38. SIGNATURE OF WITNESS [Signature]		39. SIGNATURE OF DECEASED [Signature]		40. SIGNATURE OF WITNESS [Signature]	
41. SIGNATURE OF DECEASED [Signature]		42. SIGNATURE OF WITNESS [Signature]		43. SIGNATURE OF DECEASED [Signature]		44. SIGNATURE OF WITNESS [Signature]	
45. SIGNATURE OF DECEASED [Signature]		46. SIGNATURE OF WITNESS [Signature]		47. SIGNATURE OF DECEASED [Signature]		48. SIGNATURE OF WITNESS [Signature]	
49. SIGNATURE OF DECEASED [Signature]		50. SIGNATURE OF WITNESS [Signature]		51. SIGNATURE OF DECEASED [Signature]		52. SIGNATURE OF WITNESS [Signature]	
53. SIGNATURE OF DECEASED [Signature]		54. SIGNATURE OF WITNESS [Signature]		55. SIGNATURE OF DECEASED [Signature]		56. SIGNATURE OF WITNESS [Signature]	
57. SIGNATURE OF DECEASED [Signature]		58. SIGNATURE OF WITNESS [Signature]		59. SIGNATURE OF DECEASED [Signature]		60. SIGNATURE OF WITNESS [Signature]	
61. SIGNATURE OF DECEASED [Signature]		62. SIGNATURE OF WITNESS [Signature]		63. SIGNATURE OF DECEASED [Signature]		64. SIGNATURE OF WITNESS [Signature]	
65. SIGNATURE OF DECEASED [Signature]		66. SIGNATURE OF WITNESS [Signature]		67. SIGNATURE OF DECEASED [Signature]		68. SIGNATURE OF WITNESS [Signature]	
69. SIGNATURE OF DECEASED [Signature]		70. SIGNATURE OF WITNESS [Signature]		71. SIGNATURE OF DECEASED [Signature]		72. SIGNATURE OF WITNESS [Signature]	
73. SIGNATURE OF DECEASED [Signature]		74. SIGNATURE OF WITNESS [Signature]		75. SIGNATURE OF DECEASED [Signature]		76. SIGNATURE OF WITNESS [Signature]	
77. SIGNATURE OF DECEASED [Signature]		78. SIGNATURE OF WITNESS [Signature]		79. SIGNATURE OF DECEASED [Signature]		80. SIGNATURE OF WITNESS [Signature]	
81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF WITNESS [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF WITNESS [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF WITNESS [Signature]		87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF WITNESS [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF WITNESS [Signature]		91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF WITNESS [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF WITNESS [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF WITNESS [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF WITNESS [Signature]		99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF WITNESS [Signature]	

RECEIVED  
JAN 15 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01132

1133

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>43 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BLANCHE</b> Middle <b>GERTRUDE</b> Last <b>HESSON</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1886</b>		9. AGE (In years lost birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Margaret A. Keller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Jacob H. Hesson Hagerstown R4, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330x Subarachnoid Hemorrhage</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Dec 9, 1956</b> to <b>Jan 27, 1957</b> , that I last saw the deceased alive on <b>Jan 27, 1957</b> , and that death occurred at <b>10/18</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		M.D. <b>159 W. Washington St. Hagerstown, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman M.D.</b>		<b>159 W. Washington St. Hagerstown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>Jan. 29, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

Wm. G. Hunt U-Prov.

1957

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01133

1190

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Y2 FUNKSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>111 NORTH ANTIETAM STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY CARL HOOVER</u>				4. DATE OF DEATH Month Day Year <u>JANUARY - 16 - 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY - 17 - 1895</u>	
9. AGE (In years last birthday) <u>61-11-29</u> rs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POTOMAC EDISON CO.</u>		11. BIRTHPLACE (State or foreign country) <u>SHARPSBURG WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN THOMAS HOOVER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA KATHERINE DRENNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-10-4151</u>		17. INFORMANT Address <u>MRS. LUCILLE HOOVER 111 N. ANTIETAM ST. FUNKSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X METASTATIC CARCINOMA</u> DUE TO (b) <u>CARCINOMA OF PANCREAS</u> DUE TO (c) <u>1-2 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/30</u> , 19 <u>56</u> , to <u>1/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>57</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>135 N. Potomac St. 1/18/57</u>				DATE SIGNED <u>1/18/57</u>			
PHYSICIAN'S NAME (Type) <u>Hagerstown, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JANUARY - 19 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPSBURG WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO WASH. CO. MD.</u>				24. REC'D BY REGISTRAR <u>Jan. 22, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

# CERTIFICATE OF DEATH

MAKALAND STATE DEPARTMENT OF HEALTH - BATHINGORE 18

5-20-1957

<p>1. NAME OF DECEASED                  2. SEX                  3. AGE                  4. DATE OF BIRTH                  5. PLACE OF BIRTH                  6. OCCUPATION                  7. MARITAL STATUS                  8. EDUCATION                  9. RELIGION                  10. RACE                  11. COLOR                  12. HEIGHT                  13. WEIGHT                  14. BUILD                  15. HAIR                  16. EYES                  17. SKIN                  18. TENDRILS                  19. TEETH                  20. NAILS                  21. FINGERS                  22. TOES                  23. FEET                  24. HANDS                  25. WRISTS                  26. ELBOWS                  27. SHOULDERS                  28. NECK                  29. THROAT                  30. CHEST                  31. BACK                  32. LIMBS                  33. JOINTS                  34. MOVEMENTS                  35. SENSATIONS                  36. PAIN                  37. FEVER                  38. SWEAT                  39. URINE                  40. STOOL                  41. SLEEP                  42. APPETITE                  43. DIGESTION                  44. RESPIRATION                  45. CIRCULATION                  46. NERVOUS SYSTEM                  47. MENTAL STATE                  48. HISTORY                  49. CAUSE OF DEATH                  50. MANNER OF DEATH                  51. SIGNATURE OF DECEASED                  52. SIGNATURE OF WITNESSES                  53. SIGNATURE OF PHYSICIAN                  54. SIGNATURE OF REGISTRAR                  55. DATE OF DEATH                  56. PLACE OF DEATH                  57. TIME OF DEATH                  58. SEX                  59. AGE                  60. DATE OF BIRTH                  61. PLACE OF BIRTH                  62. OCCUPATION                  63. MARITAL STATUS                  64. EDUCATION                  65. RELIGION                  66. RACE                  67. COLOR                  68. HEIGHT                  69. WEIGHT                  70. BUILD                  71. HAIR                  72. EYES                  73. SKIN                  74. TENDRILS                  75. TEETH                  76. NAILS                  77. FINGERS                  78. TOES                  79. FEET                  80. HANDS                  81. WRISTS                  82. ELBOWS                  83. SHOULDERS                  84. NECK                  85. THROAT                  86. CHEST                  87. BACK                  88. LIMBS                  89. JOINTS                  90. MOVEMENTS                  91. SENSATIONS                  92. PAIN                  93. FEVER                  94. SWEAT                  95. URINE                  96. STOOL                  97. SLEEP                  98. APPETITE                  99. DIGESTION                  100. RESPIRATION                  101. CIRCULATION                  102. NERVOUS SYSTEM                  103. MENTAL STATE                  104. HISTORY                  105. CAUSE OF DEATH                  106. MANNER OF DEATH                  107. SIGNATURE OF DECEASED                  108. SIGNATURE OF WITNESSES                  109. SIGNATURE OF PHYSICIAN                  110. SIGNATURE OF REGISTRAR                  111. DATE OF DEATH                  112. PLACE OF DEATH                  113. TIME OF DEATH                  114. SEX                  115. AGE                  116. DATE OF BIRTH                  117. PLACE OF BIRTH                  118. OCCUPATION                  119. MARITAL STATUS                  120. EDUCATION                  121. RELIGION                  122. RACE                  123. COLOR                  124. HEIGHT                  125. WEIGHT                  126. BUILD                  127. HAIR                  128. EYES                  129. SKIN                  130. TENDRILS                  131. TEETH                  132. NAILS                  133. FINGERS                  134. TOES                  135. FEET                  136. HANDS                  137. WRISTS                  138. ELBOWS                  139. SHOULDERS                  140. NECK                  141. THROAT                  142. CHEST                  143. BACK                  144. LIMBS                  145. JOINTS                  146. MOVEMENTS                  147. SENSATIONS                  148. PAIN                  149. FEVER                  150. SWEAT                  151. URINE                  152. STOOL                  153. SLEEP                  154. APPETITE                  155. DIGESTION                  156. RESPIRATION                  157. CIRCULATION                  158. NERVOUS SYSTEM                  159. MENTAL STATE                  160. HISTORY                  161. CAUSE OF DEATH                  162. MANNER OF DEATH                  163. SIGNATURE OF DECEASED                  164. SIGNATURE OF WITNESSES                  165. SIGNATURE OF PHYSICIAN                  166. SIGNATURE OF REGISTRAR                  167. DATE OF DEATH                  168. PLACE OF DEATH                  169. TIME OF DEATH                  170. SEX                  171. AGE                  172. DATE OF BIRTH                  173. PLACE OF BIRTH                  174. OCCUPATION                  175. MARITAL STATUS                  176. EDUCATION                  177. RELIGION                  178. RACE                  179. COLOR                  180. HEIGHT                  181. WEIGHT                  182. BUILD                  183. HAIR                  184. EYES                  185. SKIN                  186. TENDRILS                  187. TEETH                  188. NAILS                  189. FINGERS                  190. TOES                  191. FEET                  192. HANDS                  193. WRISTS                  194. ELBOWS                  195. SHOULDERS                  196. NECK                  197. THROAT                  198. CHEST                  199. BACK                  200. LIMBS                  201. JOINTS                  202. MOVEMENTS                  203. SENSATIONS                  204. PAIN                  205. FEVER                  206. SWEAT                  207. URINE                  208. STOOL                  209. SLEEP                  210. APPETITE                  211. DIGESTION                  212. RESPIRATION                  213. CIRCULATION                  214. NERVOUS SYSTEM                  215. MENTAL STATE                  216. HISTORY                  217. CAUSE OF DEATH                  218. MANNER OF DEATH                  219. SIGNATURE OF DECEASED                  220. SIGNATURE OF WITNESSES                  221. SIGNATURE OF PHYSICIAN                  222. SIGNATURE OF REGISTRAR                  223. DATE OF DEATH                  224. PLACE OF DEATH                  225. TIME OF DEATH                  226. SEX                  227. AGE                  228. DATE OF BIRTH                  229. PLACE OF BIRTH                  230. OCCUPATION                  231. MARITAL STATUS                  232. EDUCATION                  233. RELIGION                  234. RACE                  235. COLOR                  236. HEIGHT                  237. WEIGHT                  238. BUILD                  239. HAIR                  240. EYES                  241. SKIN                  242. TENDRILS                  243. TEETH                  244. NAILS                  245. FINGERS                  246. TOES                  247. FEET                  248. HANDS                  249. WRISTS                  250. ELBOWS                  251. SHOULDERS                  252. NECK                  253. THROAT                  254. CHEST                  255. BACK                  256. LIMBS                  257. JOINTS                  258. MOVEMENTS                  259. SENSATIONS                  260. PAIN                  261. FEVER                  262. SWEAT                  263. URINE                  264. STOOL                  265. SLEEP                  266. APPETITE                  267. DIGESTION                  268. RESPIRATION                  269. CIRCULATION                  270. NERVOUS SYSTEM                  271. MENTAL STATE                  272. HISTORY                  273. CAUSE OF DEATH                  274. MANNER OF DEATH                  275. SIGNATURE OF DECEASED                  276. SIGNATURE OF WITNESSES                  277. SIGNATURE OF PHYSICIAN                  278. SIGNATURE OF REGISTRAR                  279. DATE OF DEATH                  280. PLACE OF DEATH                  281. TIME OF DEATH                  282. SEX                  283. AGE                  284. DATE OF BIRTH                  285. PLACE OF BIRTH                  286. OCCUPATION                  287. MARITAL STATUS                  288. EDUCATION                  289. RELIGION                  290. RACE                  291. COLOR                  292. HEIGHT                  293. WEIGHT                  294. BUILD                  295. HAIR                  296. EYES                  297. SKIN                  298. TENDRILS                  299. TEETH                  300. NAILS                  301. FINGERS                  302. TOES                  303. FEET                  304. HANDS                  305. WRISTS                  306. ELBOWS                  307. SHOULDERS                  308. NECK                  309. THROAT                  310. CHEST                  311. BACK                  312. LIMBS                  313. JOINTS                  314. MOVEMENTS                  315. SENSATIONS                  316. PAIN                  317. FEVER                  318. SWEAT                  319. URINE                  320. STOOL                  321. SLEEP                  322. APPETITE                  323. DIGESTION                  324. RESPIRATION                  325. CIRCULATION                  326. NERVOUS SYSTEM                  327. MENTAL STATE                  328. HISTORY                  329. CAUSE OF DEATH                  330. MANNER OF DEATH                  331. SIGNATURE OF DECEASED                  332. SIGNATURE OF WITNESSES                  333. SIGNATURE OF PHYSICIAN                  334. SIGNATURE OF REGISTRAR                  335. DATE OF DEATH                  336. PLACE OF DEATH                  337. TIME OF DEATH                  338. SEX                  339. AGE                  340. DATE OF BIRTH                  341. PLACE OF BIRTH                  342. OCCUPATION                  343. MARITAL STATUS                  344. EDUCATION                  345. RELIGION                  346. RACE                  347. COLOR                  348. HEIGHT                  349. WEIGHT                  350. BUILD                  351. HAIR                  352. EYES                  353. SKIN                  354. TENDRILS                  355. TEETH                  356. NAILS                  357. FINGERS                  358. TOES                  359. FEET                  360. HANDS                  361. WRISTS                  362. ELBOWS                  363. SHOULDERS                  364. NECK                  365. THROAT                  366. CHEST                  367. BACK                  368. LIMBS                  369. JOINTS                  370. MOVEMENTS                  371. SENSATIONS                  372. PAIN                  373. FEVER                  374. SWEAT                  375. URINE                  376. STOOL                  377. SLEEP                  378. APPETITE                  379. DIGESTION                  380. RESPIRATION                  381. CIRCULATION                  382. NERVOUS SYSTEM                  383. MENTAL STATE                  384. HISTORY                  385. CAUSE OF DEATH                  386. MANNER OF DEATH                  387. SIGNATURE OF DECEASED                  388. SIGNATURE OF WITNESSES                  389. SIGNATURE OF PHYSICIAN                  390. SIGNATURE OF REGISTRAR                  391. DATE OF DEATH                  392. PLACE OF DEATH                  393. TIME OF DEATH                  394. SEX                  395. AGE                  396. DATE OF BIRTH                  397. PLACE OF BIRTH                  398. OCCUPATION                  399. MARITAL STATUS                  400. EDUCATION                  401. RELIGION                  402. RACE                  403. COLOR                  404. HEIGHT                  405. WEIGHT                  406. BUILD                  407. HAIR                  408. EYES                  409. SKIN                  410. TENDRILS                  411. TEETH                  412. NAILS                  413. FINGERS                  414. TOES                  415. FEET                  416. HANDS                  417. WRISTS                  418. ELBOWS                  419. SHOULDERS                  420. NECK                  421. THROAT                  422. CHEST                  423. BACK                  424. LIMBS                  425. JOINTS                  426. MOVEMENTS                  427. SENSATIONS                  428. PAIN                  429. FEVER                  430. SWEAT                  431. URINE                  432. STOOL                  433. SLEEP                  434. APPETITE                  435. DIGESTION                  436. RESPIRATION                  437. CIRCULATION                  438. NERVOUS SYSTEM                  439. MENTAL STATE                  440. HISTORY                  441. CAUSE OF DEATH                  442. MANNER OF DEATH                  443. SIGNATURE OF DECEASED                  444. SIGNATURE OF WITNESSES                  445. SIGNATURE OF PHYSICIAN                  446. SIGNATURE OF REGISTRAR                  447. DATE OF DEATH                  448. PLACE OF DEATH                  449. TIME OF DEATH                  450. SEX                  451. AGE                  452. DATE OF BIRTH                  453. PLACE OF BIRTH                  454. OCCUPATION                  455. MARITAL STATUS                  456. EDUCATION                  457. RELIGION                  458. RACE                  459. COLOR                  460. HEIGHT                  461. WEIGHT                  462. BUILD                  463. HAIR                  464. EYES                  465. SKIN                  466. TENDRILS                  467. TEETH                  468. NAILS                  469. FINGERS                  470. TOES                  471. FEET                  472. HANDS                  473. WRISTS                  474. ELBOWS                  475. SHOULDERS                  476. NECK                  477. THROAT                  478. CHEST                  479. BACK                  480. LIMBS                  481. JOINTS                  482. MOVEMENTS                  483. SENSATIONS                  484. PAIN                  485. FEVER                  486. SWEAT                  487. URINE                  488. STOOL                  489. SLEEP                  490. APPETITE                  491. DIGESTION                  492. RESPIRATION                  493. CIRCULATION                  494. NERVOUS SYSTEM                  495. MENTAL STATE                  496. HISTORY                  497. CAUSE OF DEATH                  498. MANNER OF DEATH                  499. SIGNATURE OF DECEASED                  500. SIGNATURE OF WITNESSES                  501. SIGNATURE OF PHYSICIAN                  502. SIGNATURE OF REGISTRAR                  503. DATE OF DEATH                  504. PLACE OF DEATH                  505. TIME OF DEATH                  506. SEX                  507. AGE                  508. DATE OF BIRTH                  509. PLACE OF BIRTH                  510. OCCUPATION                  511. MARITAL STATUS                  512. EDUCATION                  513. RELIGION                  514. RACE                  515. COLOR                  516. HEIGHT                  517. WEIGHT                  518. BUILD                  519. HAIR                  520. EYES                  521. SKIN                  522. TENDRILS                  523. TEETH                  524. NAILS                  525. FINGERS                  526. TOES                  527. FEET                  528. HANDS                  529. WRISTS                  530. ELBOWS                  531. SHOULDERS                  532. NECK                  533. THROAT                  534. CHEST                  535. BACK                  536. LIMBS                  537. JOINTS                  538. MOVEMENTS                  539. SENSATIONS                  540. PAIN                  541. FEVER                  542. SWEAT                  543. URINE                  544. STOOL                  545. SLEEP                  546. APPETITE                  547. DIGESTION                  548. RESPIRATION                  549. CIRCULATION                  550. NERVOUS SYSTEM                  551. MENTAL STATE                  552. HISTORY                  553. CAUSE OF DEATH                  554. MANNER OF DEATH                  555. SIGNATURE OF DECEASED                  556. SIGNATURE OF WITNESSES                  557. SIGNATURE OF PHYSICIAN                  558. SIGNATURE OF REGISTRAR                  559. DATE OF DEATH                  560. PLACE OF DEATH                  561. TIME OF DEATH                  562. SEX                  563. AGE                  564. DATE OF BIRTH                  565. PLACE OF BIRTH                  566. OCCUPATION                  567. MARITAL STATUS                  568. EDUCATION                  569. RELIGION                  570. RACE                  571. COLOR                  572. HEIGHT                  573. WEIGHT                  574. BUILD                  575. HAIR                  576. EYES                  577. SKIN                  578. TENDRILS                  579. TEETH                  580. NAILS                  581. FINGERS                  582. TOES                  583. FEET                  584. HANDS                  585. WRISTS                  586. ELBOWS                  587. SHOULDERS                  588. NECK                  589. THROAT                  590. CHEST                  591. BACK                  592. LIMBS                  593. JOINTS                  594. MOVEMENTS                  595. SENSATIONS                  596. PAIN                  597. FEVER                  598. SWEAT                  599. URINE                  600. STOOL                  601. SLEEP                  602. APPETITE                  603. DIGESTION                  604. RESPIRATION                  605. CIRCULATION                  606. NERVOUS SYSTEM                  607. MENTAL STATE                  608. HISTORY                  609. CAUSE OF DEATH                  610. MANNER OF DEATH                  611. SIGNATURE OF DECEASED                  612. SIGNATURE OF WITNESSES                  613. SIGNATURE OF PHYSICIAN                  614. SIGNATURE OF REGISTRAR                  615. DATE OF DEATH                  616. PLACE OF DEATH                  617. TIME OF DEATH                  618. SEX                  619. AGE                  620. DATE OF BIRTH                  621. PLACE OF BIRTH                  622. OCCUPATION                  623. MARITAL STATUS                  624. EDUCATION                  625. RELIGION                  626. RACE                  627. COLOR                  628. HEIGHT                  629. WEIGHT                  630. BUILD                  631. HAIR                  632. EYES                  633. SKIN                  634. TENDRILS                  635. TEETH                  636. NAILS                  637. FINGERS                  638. TOES                  639. FEET                  640. HANDS                  641. WRISTS                  642. ELBOWS                  643. SHOULDERS                  644. NECK                  645. THROAT                  646. CHEST                  647. BACK                  648. LIMBS                  649. JOINTS                  650. MOVEMENTS                  651. SENSATIONS                  652. PAIN                  653. FEVER                  654. SWEAT                  655. URINE                  656. STOOL                  657. SLEEP                  658. APPETITE                  659. DIGESTION                  660. RESPIRATION                  661. CIRCULATION                  662. NERVOUS SYSTEM                  663. MENTAL STATE                  664. HISTORY                  665. CAUSE OF DEATH                  666. MANNER OF DEATH                  667. SIGNATURE OF DECEASED                  668. SIGNATURE OF WITNESSES                  669. SIGNATURE OF PHYSICIAN                  670. SIGNATURE OF REGISTRAR                  671. DATE OF DEATH                  672. PLACE OF DEATH                  673. TIME OF DEATH                  674. SEX                  675. AGE                  676. DATE OF BIRTH                  677. PLACE OF BIRTH                  678. OCCUPATION                  679. MARITAL STATUS                  680. EDUCATION                  681. RELIGION                  682. RACE                  683. COLOR                  684. HEIGHT                  685. WEIGHT                  686. BUILD                  687. HAIR                  688. EYES                  689. SKIN                  690. TENDRILS                  691. TEETH                  692. NAILS                  693. FINGERS                  694. TOES                  695. FEET                  696. HANDS                  697. WRISTS                  698. ELBOWS                  699. SHOULDERS                  700. NECK                  701. THROAT                  702. CHEST                  703. BACK                  704. LIMBS                  705. JOINTS                  706. MOVEMENTS                  707. SENSATIONS                  708. PAIN                  709. FEVER                  710. SWEAT                  711. URINE                  712. STOOL                  713. SLEEP                  714. APPETITE                  715. DIGESTION                  716. RESPIRATION                  717. CIRCULATION                  718. NERVOUS SYSTEM                  719. MENTAL STATE                  720. HISTORY                  721. CAUSE OF DEATH                  722. MANNER OF DEATH                  723. SIGNATURE OF DECEASED                  724. SIGNATURE OF WITNESSES                  725. SIGNATURE OF PHYSICIAN                  726. SIGNATURE OF REGISTRAR                  727. DATE OF DEATH                  728. PLACE OF DEATH                  729. TIME OF DEATH                  730. SEX                  731. AGE                  732. DATE OF BIRTH                  733. PLACE OF BIRTH                  734. OCCUPATION                  735. MARITAL STATUS                  736. EDUCATION                  737. RELIGION                  738. RACE                  739. COLOR                  740. HEIGHT                  741. WEIGHT                  742. BUILD                  743. HAIR                  744. EYES                  745. SKIN                  746. TENDRILS                  747. TEETH                  748. NAILS                  749. FINGERS                  750. TOES                  751. FEET                  752. HANDS                  753. WRISTS                  754. ELBOWS                  755. SHOULDERS                  756. NECK                  757. THROAT                  758. CHEST                  759. BACK                  760. LIMBS                  761. JOINTS                  762. MOVEMENTS                  763. SENSATIONS                  764. PAIN                  765. FEVER                  766. SWEAT                  767. URINE                  768. STOOL                  769. SLEEP                  770. APPETITE                  771. DIGESTION                  772. RESPIRATION                  773. CIRCULATION                  774. NERVOUS SYSTEM                  775. MENTAL STATE                  776. HISTORY                  777. CAUSE OF DEATH                  778. MANNER OF DEATH                  779. SIGNATURE OF DECEASED                  780. SIGNATURE OF WITNESSES                  781. SIGNATURE OF PHYSICIAN                  782. SIGNATURE OF REGISTRAR                  783. DATE OF DEATH                  784. PLACE OF DEATH                  785. TIME OF DEATH                  786. SEX                  787. AGE                  788. DATE OF BIRTH                  789. PLACE OF BIRTH                  790. OCCUPATION                  791. MARITAL STATUS                  792. EDUCATION                  793. RELIGION                  794. RACE                  795. COLOR                  796. HEIGHT                  797. WEIGHT                  798. BUILD                  799. HAIR                  800. EYES                  801. SKIN                  802. TENDRILS                  803. TEETH                  804. NAILS                  805. FINGERS                  806. TOES                  807. FEET                  808. HANDS                  809. WRISTS                  810. ELBOWS                  811. SHOULDERS                  812. NECK                  813. THROAT                  814. CHEST                  815. BACK                  816. LIMBS                  817. JOINTS                  818. MOVEMENTS                  819. SENSATIONS                  820. PAIN                  821. FEVER                  822. SWEAT                  823. URINE                  824. STOOL                  825. SLEEP                  826. APPETITE                  827. DIGESTION                  828. RESPIRATION                  829. CIRCULATION                  830. NERVOUS SYSTEM                  831. MENTAL STATE                  832. HISTORY                  833. CAUSE OF DEATH                  834. MANNER OF DEATH                  835. SIGNATURE OF DECEASED                  836. SIGNATURE OF WITNESSES                  837. SIGNATURE OF PHYSICIAN                  838. SIGNATURE OF REGISTRAR                  839. DATE OF DEATH                  840. PLACE OF DEATH                  841. TIME OF DEATH                  842. SEX                  843. AGE                  844. DATE OF BIRTH                  845. PLACE OF BIRTH                  846. OCCUPATION                  847. MARITAL STATUS                  848. EDUCATION                  849. RELIGION                  850. RACE                  851. COLOR                  852. HEIGHT                  853. WEIGHT                  854. BUILD                  855. HAIR                  856. EYES                  857. SKIN                  858. TENDRILS                  859. TEETH                  860. NAILS                  861. FINGERS                  862. TOES                  863. FEET                  864. HANDS                  865. WRISTS                  866. ELBOWS                  867. SHOULDERS                  868. NECK                  869. THROAT                  870. CHEST                  871. BACK                  872. LIMBS                  873. JOINTS                  874. MOVEMENTS                  875. SENSATIONS                  876. PAIN                  877. FEVER                  878. SWEAT                  879. URINE                  880. STOOL                  881. SLEEP                  882. APPETITE                  883. DIGESTION                  884. RESPIRATION                  885. CIRCULATION                  886. NERVOUS SYSTEM                  887. MENTAL STATE                  888. HISTORY                  889. CAUSE OF DEATH                  890. MANNER OF DEATH                  891. SIGNATURE OF DECEASED                  892. SIGNATURE OF WITNESSES                  893. SIGNATURE OF PHYSICIAN                  894. SIGNATURE OF REGISTRAR                  895. DATE OF DEATH                  896. PLACE OF DEATH                  897. TIME OF DEATH                  898. SEX                  899. AGE                  900. DATE OF BIRTH                  901. PLACE OF BIRTH                  902. OCCUPATION                  903. MARITAL STATUS                  904. EDUCATION                  905. RELIGION                  906. RACE                  907. COLOR                  908. HEIGHT                  909. WEIGHT                  910. BUILD                  911. HAIR                  912. EYES                  913. SKIN                  914. TENDRILS                  915. TEETH                  916. NAILS                  917. FINGERS                  918. TOES                  919. FEET                  920. HANDS                  921. WRISTS                  922. ELBOWS                  923. SHOULDERS                  924. NECK                  925. THROAT                  926. CHEST                  927. BACK                  928. LIMBS                  929. JOINTS                  930. MOVEMENTS                  931. SENSATIONS                  932. PAIN                  933. FEVER                  934. SWEAT                  935. URINE                  936. STOOL                  937. SLEEP                  938. APPETITE                  939. DIGESTION                  940. RESPIRATION                  941. CIRCULATION                  942. NERVOUS SYSTEM                  943. MENTAL STATE                  944. HISTORY                  945. CAUSE OF DEATH                  946. MANNER OF DEATH                  947. SIGNATURE OF DECEASED                  948. SIGNATURE OF WITNESSES                  949. SIGNATURE OF PHYSICIAN                  950. SIGNATURE OF REGISTRAR                  951. DATE OF DEATH                  952. PLACE OF DEATH                  953. TIME OF DEATH                  954. SEX                  955. AGE                  956. DATE OF BIRTH                  957. PLACE OF BIRTH                  958. OCCUPATION                  959. MARITAL STATUS                  960. EDUCATION                  961. RELIGION                  962. RACE                  963. COLOR                  964. HEIGHT                  965. WEIGHT                  966. BUILD                  967. HAIR                  968. EYES                  969. SKIN                  970. TENDRILS                  971. TEETH                  972. NAILS                  973. FINGERS                  974. TOES                  975. FEET                  976. HANDS                  977. WRISTS                  978. ELBOWS                  979. SHOULDERS                  980. NECK                  981. THROAT                  982. CHEST                  983. BACK                  984. LIMBS                  985. JOINTS                  986. MOVEMENTS                  987. SENSATIONS                  988. PAIN                  989. FEVER                  990. SWEAT                  991. URINE                  992. STOOL                  993. SLEEP                  994. APPETITE                  995. DIGESTION                  996. RESPIRATION                  997. CIRCULATION                  998. NERVOUS SYSTEM                  999. MENTAL STATE                  1000. HISTORY                  1001. CAUSE OF DEATH                  1002. MANNER OF DEATH                  1003. SIGNATURE OF DECEASED                  1004. SIGNATURE OF WITNESSES                  1005. SIGNATURE OF PHYSICIAN                  1006. SIGNATURE OF REGISTRAR                  1007. DATE OF DEATH                  1008. PLACE OF DEATH                  1009. TIME OF DEATH                  1010. SEX                  1011. AGE                  1012. DATE OF BIRTH                  1013. PLACE OF BIRTH                  1014. OCCUPATION                  1015. MARITAL STATUS                  1016. EDUCATION                  1017. RELIGION                  1018. RACE                  1019. COLOR                  1020. HEIGHT                  1021. WEIGHT                  1022. BUILD                  1023. HAIR                  1024. EYES                  1025. SKIN                  1026. TENDRILS                  1027. TEETH                  1028. NAILS                  1029. FINGERS                  1030. TOES                  1031. FEET                  1032. HANDS                  1033. WRISTS                  1034. ELBOWS                  1035. SHOULDERS                  1036. NECK                  1037. THROAT                  1038. CHEST</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01134

1134

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Jackson Nursing Home</b>		d. STREET ADDRESS <b>1 102 E. Baltimore St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Isabel</b> Middle <b>Brown</b> Last <b>Hull</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 31, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>County Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Health Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Brown</b>		14. MOTHER'S MAIDEN NAME <b>Lily Stutzman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>David F. Hull</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>10 min</b> <b>37 min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260XD Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April</b> , 19 <b>51</b> , to <b>Jan-10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 10</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Lloyd A. Hoffman</b> M.D. <b>214 N. Petomac st. 1/11/57</b>			
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>			
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-14-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		24. REC'D BY REGISTRAR <b>Jan 16 1957</b>	
ADDRESS <b>Hagerstown Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Wesley Bowers</b>	



CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Date of Birth		Place of Birth		Place of Death		Cause of Death		Time of Death		Signature of Physician		Signature of Registrar	
Washington		50 years		Male		White		White		Jan. 21, 1885		Washington, D. C.		Washington, D. C.		Heart Disease		10:30 P.M.		J. H. Brown		J. H. Brown	
Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship	
Charles Brown		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son	
Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship		Name of Informant		Relationship	
David P. Hall		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son		J. H. Brown		Son	

**RECEIVED**  
JAN 18 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01135

1191

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Leitersburg</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Lane Farm</u>				d. STREET ADDRESS <u>909 Fawn Street</u>			
3. NAME OF DECEASED (Type or print) First <u>ARSENIO</u> Middle <u>IPPOLITO</u> Last <u>IPPOLITO</u>				4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1897</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tally Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Naples, Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Antonio Ippolito</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Gagliardi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-2851</u>		17. INFORMANT <u>Mr. George Ippolito</u> Address <u>Baltimore, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic delirium</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic alcoholism</u> DUE TO (c) <u>Arterio-sclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>72.</u> <u>9m</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.0</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>27th</u> , 19 <u>57</u> , to <u>31st</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>30th</u> , 19 <u>57</u> , and that death occurred at <u>1:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1154 North</u> DATE SIGNED <u>1/31/57</u> ACTUAL SIGNATURE <u>E. Edgar Hoover</u> M.D. <u>E. Edgar Hoover</u> PHYSICIAN'S NAME (Type) <u>E. Edgar Hoover</u> <u>Hagerman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>FEB. 4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>4430 BELAIR RD BAL. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Deller Moore</u>				ADDRESS <u>322 S. HIGH ST</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles F. Bowers</u>							

11

BUREAU V. S.

FEB 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01136	
CERTIFICATE OF DEATH										Reg. Dist. No. 302	
1. PLACE OF DEATH o. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					c. LENGTH OF STAY IN 1b <b>47YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>426 S. POTOMAC ST.</b>					d. STREET ADDRESS <b>426 S. POTOMAC ST.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARVIN</b> First <b>LEROY</b> Middle <b>KANIPER</b> Last			4. DATE OF DEATH <b>JANUARY</b> Month <b>22</b> Day <b>19</b> Year <b>57</b>								
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/29/1884</b>		9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN STORE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN KANIPER</b>					14. MOTHER'S MAIDEN NAME <b>LAURA ?</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>218-30-9219A</b>		17. INFORMANT <b>MRS. AMELIA C. KANIPER</b>			Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic heart disease</b> DUE TO (c) <b>10 yrs</b>										INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign Prostatic Hypertrophy</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept. 10, 1955</b> , to <b>Jan. 22, 1957</b> , that I last saw the deceased alive on <b>Nov. 15, 1956</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Maryland</b> DATE SIGNED <b>Edward W. Ditto</b>											
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D. PHYSICIAN'S NAME (Type) <b>217 W. Washington Street</b> <b>Hagerstown, Maryland</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>1/24/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>			22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. F. Norment</b> ADDRESS <b>Hagerstown, Md.</b>					24. REC'D BY REGISTRAR <b>Jan. 28, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>				

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JAN 30 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1136

CERTIFICATE OF DEATH

01137

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>940 the Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ROUSKULP</u> Last <u>KELLER</u>				4. DATE OF DEATH Month <u>January</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Harry W. Rouskulp</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Downin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-26-1160</u>		17. INFORMANT <u>Mrs. Catharine R. Fleigh</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>June 55</u> , 19 <u>55</u> , to <u>Jan 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>		DATE SIGNED <u>1/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Robert T. V. H. Campbell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/26/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 26. 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Black Boevers</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hoffman

01138

1137

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>Washington</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALVEY</b> Middle <b>FOSTER</b> Last <b>KOOGLE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 8 1868</b>	
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Self Employed Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Middletown Fred Co Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John W. Koogle</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Sheffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Harry L. Koogle 726 Chestnut st</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis - Mar. 1955</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown Md.</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>Mar. 1955</b> , to <b>Jan. 9, 1957</b> , that I last saw the deceased alive on <b>Jan. 6, 1957</b> , and that death occurred at <b>1 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b>				ADDRESS (Street, city or town, state) <b>2112 N. Potomac St. Hagerstown, Md.</b>			
DATE SIGNED <b>1/10/57</b>							
PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>			
24a. REC'D BY REGISTRAR <b>Jan. 14 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MARYLAND

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. RACE [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]		9. CAUSE OF DEATH [REDACTED]	
10. MANNER OF DEATH [REDACTED]		11. SIGNATURE OF DECEASED [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF CLERK [REDACTED]		15. SIGNATURE OF REGISTRAR [REDACTED]	

BUREAU V. S.

JAN 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01139

1192

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route #6, Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph Leslie Koons</u>		4. DATE OF DEATH Month Day Year <u>January 7 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 15 1890</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm work</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Koons</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Newman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>320-16-332</u>	
17. INFORMANT <u>Mr. Elizabeth Koons, RD #6, Hagerstown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic Carcinoma</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of pancreas</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 1/2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>54</u> , to <u>Present</u> , 19____, that I last saw the deceased alive on <u>January 6</u> , 19 <u>57</u> , and that death occurred at <u>6:00A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		DATE SIGNED <u>1/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		ADDRESS (Street, city or town, state) <u>136 North Potomac St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Co Penna</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley M. Zimmerman</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 9. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>	



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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1138

## CERTIFICATE OF DEATH

01140

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Boonesboro Rt. 2</b>	
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>Edward</b> Last <b>Lapole</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1882</b>
9. AGE (In years, months, days, hours, minutes) <b>75</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>3</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (State or foreign country) <b>Zittlestown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William Lapole</b>		14. MOTHER'S MAIDEN NAME <b>Lana Rent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>214-09-0316</b>	
17. INFORMANT <b>Mrs. Roy Robinson</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute infarction of Pericardial Gland</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Toxemia cachexia</b> DUE TO (c) <b>Ca of Pancreas</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/21/56</b> , 19____, to <b>1/14/57</b> , 19____, that I last saw the deceased alive on <b>1/14/57</b> , 19____, and that death occurred at <b>7:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. L. H. Brumback</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. L. H. Brumback</b>		DATE SIGNED <b>1/15/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-17-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24. REC'D BY REGISTRAR <b>Jan. 21, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Cowers</b>	

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[illegible]

114-02055 Mrs. Roy Robinson Hagerstown Md.

BUREAU V.

JAN 23 1957

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92-51-1 13145

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01141

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>THOMAS</b> Last <b>LEITER</b>				4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 18, 1877</b>	
9. AGE (In years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Head Time Keeper Railroad</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George T. Leiter, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Ash</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-10-5591</b>		17. INFORMANT <b>Ezra D. Chapman</b>		Address <b>Hagerstown, Boonsboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b></b> (c) <b></b> DUE TO (a), stating the underlying cause lost. (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>900.0 Fractured skull and concussion</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down the steps at Dagmar Hotel where he resided</b>			
20c. TIME OF INJURY Hour <b>5:00 P.M.</b> Month, Day, Year <b>Dec 28 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hotel</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb. 2, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles J. Zovvero</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

FEB - 5 - 1957

BUREAU V. 3

MAYNARD STATE DEPARTMENT OF HEALTH-EASTON, IS		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
NAME OF DECEASED		AGE	
SEX		RACE	
DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		SIGNATURE OF EXAMINER	
LOCALITY		COUNTY	
STATE		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01142	
JAN 20 1957 1-16-57 4-56-57										Reg. Dist. No. 302	
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75x.3 Greencastle				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home 1223 Virginia Ave.					d. STREET ADDRESS W. Baltimore St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle ELLEN Last LESHER			4. DATE OF DEATH Month Jan. Day 3 Year 1957								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1868		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) York County, Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Mathias Blauser					14. MOTHER'S MAIDEN NAME Caroline Spahr						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Robert F. Leshar Address Sharpsburg Pike Hagerstown, Md. R #3						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903.0 Pulmonary Embolism due to Thrombosis DUE TO (b) Complications intertracheal DUE TO (c) fracture right femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) general arteriosclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on small rug in hallway of son's home						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2:30 p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Wash. (County) Md.		
21. I certify that I attended the deceased from Dec 7, 1956, to Jan 3, 1957, that I last saw the deceased alive on Jan 1, 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE E. W. Ditto III M.D.					ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.					DATE SIGNED 1/4/57	
PHYSICIAN'S NAME (Type) E. W. Ditto III M.D.					21 W. Washington St. Hagerstown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Jan. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) Hagerstown (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.					ADDRESS Wm. A. Horst & Son.		24a. REC'D BY REGISTRAR Jan 6. 1957		24b. REGISTRAR'S SIGNATURE [Signature]		

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male	
3. AGE 45		4. DATE OF DEATH JAN 10 1957	
5. PLACE OF DEATH At Home		6. PLACE OF BIRTH New York, N.Y.	
7. OCCUPATION Salesman		8. MARITAL STATUS Married	
9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
15. SIGNATURE OF CLERK		16. SIGNATURE OF CHIEF CLERK	
17. SIGNATURE OF ASSISTANT CLERK		18. SIGNATURE OF DEPUTY CLERK	
19. SIGNATURE OF DEPUTY ASSISTANT CLERK		20. SIGNATURE OF DEPUTY DEPUTY CLERK	
21. SIGNATURE OF DEPUTY DEPUTY CLERK		22. SIGNATURE OF DEPUTY DEPUTY CLERK	
23. SIGNATURE OF DEPUTY DEPUTY CLERK		24. SIGNATURE OF DEPUTY DEPUTY CLERK	
25. SIGNATURE OF DEPUTY DEPUTY CLERK		26. SIGNATURE OF DEPUTY DEPUTY CLERK	
27. SIGNATURE OF DEPUTY DEPUTY CLERK		28. SIGNATURE OF DEPUTY DEPUTY CLERK	
29. SIGNATURE OF DEPUTY DEPUTY CLERK		30. SIGNATURE OF DEPUTY DEPUTY CLERK	
31. SIGNATURE OF DEPUTY DEPUTY CLERK		32. SIGNATURE OF DEPUTY DEPUTY CLERK	
33. SIGNATURE OF DEPUTY DEPUTY CLERK		34. SIGNATURE OF DEPUTY DEPUTY CLERK	
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37. SIGNATURE OF DEPUTY DEPUTY CLERK		38. SIGNATURE OF DEPUTY DEPUTY CLERK	
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43. SIGNATURE OF DEPUTY DEPUTY CLERK		44. SIGNATURE OF DEPUTY DEPUTY CLERK	
45. SIGNATURE OF DEPUTY DEPUTY CLERK		46. SIGNATURE OF DEPUTY DEPUTY CLERK	
47. SIGNATURE OF DEPUTY DEPUTY CLERK		48. SIGNATURE OF DEPUTY DEPUTY CLERK	
49. SIGNATURE OF DEPUTY DEPUTY CLERK		50. SIGNATURE OF DEPUTY DEPUTY CLERK	
51. SIGNATURE OF DEPUTY DEPUTY CLERK		52. SIGNATURE OF DEPUTY DEPUTY CLERK	
53. SIGNATURE OF DEPUTY DEPUTY CLERK		54. SIGNATURE OF DEPUTY DEPUTY CLERK	
55. SIGNATURE OF DEPUTY DEPUTY CLERK		56. SIGNATURE OF DEPUTY DEPUTY CLERK	
57. SIGNATURE OF DEPUTY DEPUTY CLERK		58. SIGNATURE OF DEPUTY DEPUTY CLERK	
59. SIGNATURE OF DEPUTY DEPUTY CLERK		60. SIGNATURE OF DEPUTY DEPUTY CLERK	
61. SIGNATURE OF DEPUTY DEPUTY CLERK		62. SIGNATURE OF DEPUTY DEPUTY CLERK	
63. SIGNATURE OF DEPUTY DEPUTY CLERK		64. SIGNATURE OF DEPUTY DEPUTY CLERK	
65. SIGNATURE OF DEPUTY DEPUTY CLERK		66. SIGNATURE OF DEPUTY DEPUTY CLERK	
67. SIGNATURE OF DEPUTY DEPUTY CLERK		68. SIGNATURE OF DEPUTY DEPUTY CLERK	
69. SIGNATURE OF DEPUTY DEPUTY CLERK		70. SIGNATURE OF DEPUTY DEPUTY CLERK	
71. SIGNATURE OF DEPUTY DEPUTY CLERK		72. SIGNATURE OF DEPUTY DEPUTY CLERK	
73. SIGNATURE OF DEPUTY DEPUTY CLERK		74. SIGNATURE OF DEPUTY DEPUTY CLERK	
75. SIGNATURE OF DEPUTY DEPUTY CLERK		76. SIGNATURE OF DEPUTY DEPUTY CLERK	
77. SIGNATURE OF DEPUTY DEPUTY CLERK		78. SIGNATURE OF DEPUTY DEPUTY CLERK	
79. SIGNATURE OF DEPUTY DEPUTY CLERK		80. SIGNATURE OF DEPUTY DEPUTY CLERK	
81. SIGNATURE OF DEPUTY DEPUTY CLERK		82. SIGNATURE OF DEPUTY DEPUTY CLERK	
83. SIGNATURE OF DEPUTY DEPUTY CLERK		84. SIGNATURE OF DEPUTY DEPUTY CLERK	
85. SIGNATURE OF DEPUTY DEPUTY CLERK		86. SIGNATURE OF DEPUTY DEPUTY CLERK	
87. SIGNATURE OF DEPUTY DEPUTY CLERK		88. SIGNATURE OF DEPUTY DEPUTY CLERK	
89. SIGNATURE OF DEPUTY DEPUTY CLERK		90. SIGNATURE OF DEPUTY DEPUTY CLERK	
91. SIGNATURE OF DEPUTY DEPUTY CLERK		92. SIGNATURE OF DEPUTY DEPUTY CLERK	
93. SIGNATURE OF DEPUTY DEPUTY CLERK		94. SIGNATURE OF DEPUTY DEPUTY CLERK	
95. SIGNATURE OF DEPUTY DEPUTY CLERK		96. SIGNATURE OF DEPUTY DEPUTY CLERK	
97. SIGNATURE OF DEPUTY DEPUTY CLERK		98. SIGNATURE OF DEPUTY DEPUTY CLERK	
99. SIGNATURE OF DEPUTY DEPUTY CLERK		100. SIGNATURE OF DEPUTY DEPUTY CLERK	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG210 1-29-57 et

## CERTIFICATE OF DEATH

01143

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>328 N. Mulberry</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nora Blanch Lewis</b>				4. DATE OF DEATH Month Day Year <b>January 18 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar 15, 1882</b>	
9. AGE (In years lost birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Die Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Silk Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Mahlon Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Susan L. Betts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Bernard A. Lewis Detroit Mich.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0 Dry Gangrene left great toe</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Jan 10, 1957</b> , to <b>Jan 15, 1957</b> , that I last saw the deceased alive on <b>Jan 15, 1957</b> , and that death occurred at <b>1:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>21414 Potomac st. 1/20/57</b> ACTUAL SIGNATURE <b>Lloyd A. Hoffman</b> M.D. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman Hagerstown Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 23, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Harrison

01144

1142

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HUBERT</b> Middle <b>ROY</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17 1886</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance of Way B.O.R.R. Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Middletown Fred Co Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Cost Long</b>		14. MOTHER'S MAIDEN NAME <b>Frances Coffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-07-7703</b>	
17. INFORMANT <b>Carroll W. Long</b>		Address <b>713 George St Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> 585x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Ruptured Gall Bladder</b> DUE TO (c) <b>Acute Cholecystitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 wks</b> <b>2 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 20, 1956</b> to <b>Jan 10, 1957</b> , that I last saw the deceased alive on <b>Jan 10, 1957</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul Harrison</b>		DATE SIGNED <b>3/11/57</b>	
PHYSICIAN'S NAME (Type) <b>PAUL HARRISON</b>		<b>Hagerstown, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Jan 14 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H. Owens</b>	



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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u> hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Alfred</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 9, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired yard helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Auburn, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cyrus Long</u>		14. MOTHER'S MAIDEN NAME <u>Leanna Krummis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-8218</u>	
17. INFORMANT <u>Mrs. Catherine Sagle, Hancock, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leucemia</u> <u>204.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-25</u> , 19 <u>56</u> , to <u>1-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-1-57</u> , 19 <u></u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert P. Conrad</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>		DATE SIGNED <u>1-2-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-4-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Rogers</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 8, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

JAN 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01146

1144

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>121 E. Washington St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Charles</u> Last <u>Magaha</u>				4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 29, 1892</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cold Storage Door Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Shepardstown, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Magaha</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Swain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-5893</u>		17. INFORMANT <u>Mrs. Grace Magaha</u> Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 3, 1957</u> , to <u>Jan. 8, 1957</u> , that I last saw the deceased alive on <u>Jan. 8, 1957</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>119 North Potomac Street, 1-10-57</u> DATE SIGNED <u>Jan. 16, 1957</u>							
ACTUAL SIGNATURE <u>R. A. Bell</u> PHYSICIAN'S NAME (Type) <u>R. A. Bell</u>				M.D. <u>Hagerstown, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/11/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouzer</u> Super-Rouzer Funeral Home ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan. 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Powers</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01147  
302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>1145</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b> <b>x2</b> d. STREET ADDRESS <b>NEAR McCOYS FERRY</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WESLEY</b> Last <b>MANN</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Approx. 76 9 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GEN LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>DAVID MANN</b>		14. MOTHER'S MAIDEN NAME <b>LUCY BISHOP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>GROVER C. MANN</b>		Address <b>CHERRY RUN W. VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3rd &amp; 4th degree burns to torso and upper extremities</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burned when oil stove exploded in home</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:30 P. Nov. 17 19 57</b>		20d. INJURY OCCURRED <b>at home</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>at home</b>		20f. (City or town) <b>Rural- Clearspring Wash Md</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>1-19-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/22/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>STONE BRIDGE DUNKARD</b>	22d. LOCATION (City, town, or county) <b>HANCOCK</b> (State) <b>MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>FRED W. KRAISS</b>		24b. REGISTRAR'S SIGNATURE <b>Jan. 22, 1957</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 24 1957

BUREAU V. S.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [ ]

2. SEX: [ ]

3. AGE: [ ]

4. DATE OF DEATH: [ ]

5. PLACE OF DEATH: [ ]

6. CAUSE OF DEATH: [ ]

7. MANNER OF DEATH: [ ]

8. SIGNATURE OF EXAMINER: [ ]

9. SIGNATURE OF WITNESS: [ ]

10. SIGNATURE OF CORONER: [ ]

11. SIGNATURE OF JURY: [ ]

12. SIGNATURE OF JUDGE: [ ]

13. SIGNATURE OF CLERK: [ ]

14. SIGNATURE OF RECORDS: [ ]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Haak

01148  
3028

1146

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>6 Hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILES</u> Middle <u>JUNIOR</u> Last <u>MARSH</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 22 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wmspt Tannery</u>	
11. BIRTHPLACE (State or foreign country) <u>near Gettysburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Miles Marsh Sr</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-09-7421</u>	
17. INFORMANT <u>Mrs Blanche Marsh Williamsport Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Liver Failure</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Carcinoma of Lung</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 months</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>56</u> , to <u>10 Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 Jan</u> , 19 <u>57</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peace Haak</u> M.D.		ADDRESS (Street, city or town, state) <u>28W. Potomac Street</u> DATE SIGNED <u>11 Jan 57</u>	
PHYSICIAN'S NAME (Type) <u>PAUL HAAS, M.D.</u>		<u>Williamsport, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		24. REC'D BY REGISTRAR <u>Jan 14 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas H. Bowers</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1880		Baltimore, Md.		Jan 15, 1957		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		High School		Married		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

**RECEIVED**  
JAN 15 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO VITAL REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01149

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x0 rural Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Garver Martin		4. DATE OF DEATH Month Day Year Jan. 12 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1879
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Martin		14. MOTHER'S MAIDEN NAME Cora Garver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 716-16-9301	
17. INFORMANT Annie M. Martin, Smithsburg RD 2, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Massive gastric defecting hemorrhage		INTERVAL BETWEEN ONSET AND DEATH Jan 4 / 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4, 1957, to Jan 12, 1957, that I last saw the deceased alive on Jan 12, 1957, and that death occurred at 11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Kohler, M.D.		DATE SIGNED 1/14/57	
PHYSICIAN'S NAME (Type) George A. Kohler, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-15-57	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24. REC'D BY REGISTRAR Jan 16, 1957	
24b. REGISTRAR'S SIGNATURE Black Bowers			



# CERTIFICATE OF DEATH

Reg. Div. No.

<p>1. NAME OF DECEASED  <b>John Martin</b></p>		<p>2. SEX  <b>Male</b></p>	
<p>3. AGE  <b>30</b></p>		<p>4. DATE OF BIRTH  <b>July 20, 1927</b></p>	
<p>5. PLACE OF BIRTH  <b>St. Louis, Mo.</b></p>		<p>6. OCCUPATION  <b>Driver</b></p>	
<p>7. MARITAL STATUS  <b>Single</b></p>		<p>8. CAUSE OF DEATH  <b>Heart Disease</b></p>	
<p>9. PLACE OF DEATH  <b>St. Louis, Mo.</b></p>		<p>10. DATE OF DEATH  <b>Jan. 18, 1957</b></p>	
<p>11. SIGNATURE OF DECEASED  <i>[Signature]</i></p>		<p>12. SIGNATURE OF WITNESS  <i>[Signature]</i></p>	
<p>13. SIGNATURE OF PHYSICIAN  <i>[Signature]</i></p>		<p>14. SIGNATURE OF CORONER  <i>[Signature]</i></p>	

BUREAU V. 2

JAN 18 1957

RECEIVED

1148

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Maugansville)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELMER</u> First <u>K</u> Middle <u>MARTIN</u> Last		4. DATE OF DEATH Month <u>JAN</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1898</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel W. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Christanne Keener</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Fannie E Martin</u>	
17. INFORMANT <u>Hagerstown RD #4</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery sclerosis</u> DUE TO (c) <u>Not known</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 29</u> , 19 <u>57</u> , to <u>Jan. 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 29</u> , 19 <u>57</u> , and that death occurred at <u>1:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.		ADDRESS (Street, city or town, state) <u>148 West Washington St.</u> DATE SIGNED <u>1/30/57</u>	
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <u>Buried Feb 2 1957</u>	22b. NAME OF CEMETERY OR CREMATORY <u>Reiff Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>near Maugansville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl E. Minnich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>Feb 1 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF NEW YORK - BUREAU OF HEALTH

BUREAU V. S.

FEB 4 1957

RECEIVED

Wm. C. Johnson  
Bureau of Health

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1149

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		e. STREET ADDRESS <b>15 E. LEE ST.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN LOVING MASSIE</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 27 19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/1915</b>
9. AGE (In years last birthday) <b>41 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>BERNARD L. MASSIE</b>		14. MOTHER'S MAIDEN NAME <b>ALLIE OGDEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>W.W.#2</b>	
17. INFORMANT <b>MRS. LORENE HARGROVE MASSIE</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Congestion &amp; Edema</b> <b>545X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Postoperative cardiac failure</b> DUE TO <b>Partial resection stomach; gastric jejunostomy</b> (c) <b>Duodenojejunostomy, recent</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs</b> <b>6-8 hrs</b> <b>recent</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May</b> , 1954, to <b>January</b> , 1957, that I last saw the deceased alive on <b>January 27</b> , 1957, and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		ADDRESS (Street, city or town, state) <b>136 North Potomac Street</b> DATE SIGNED <b>1/29/57</b>	
PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		<b>Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/30/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan. 31, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN		AGE 65		SEX M		RACE W		DATE OF BIRTH JAN 1 1892	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	
NAME OF WIFE MAGGIE		AGE 60		SEX F		RACE W		DATE OF BIRTH JAN 1 1892	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	
NAME OF CHILD MAGGIE		AGE 10		SEX F		RACE W		DATE OF BIRTH JAN 1 1915	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	
NAME OF CHILD JOHN		AGE 10		SEX M		RACE W		DATE OF BIRTH JAN 1 1915	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	
NAME OF CHILD MAGGIE		AGE 10		SEX F		RACE W		DATE OF BIRTH JAN 1 1915	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	
NAME OF CHILD JOHN		AGE 10		SEX M		RACE W		DATE OF BIRTH JAN 1 1915	
PLACE OF BIRTH BALTIMORE, MD.		OCCUPATION LABORER		EDUCATION 8		MARRIAGE M		DATE OF MARRIAGE JAN 1 1915	

BUREAU V. S.

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## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>20 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 PARK LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHRISTOPHER</b> Middle <b>ERVIN</b> Last <b>McEWEN SR.</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>19</b> Year <b>57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED GROCER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN STORE</b>	11. BIRTHPLACE (State or foreign country) <b>TENNESSE</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JAMES K. McEWEN</b>		14. MOTHER'S MAIDEN NAME <b>? SHUTE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-18-1327</b>	17. INFORMANT <b>MRS. ILDA V. McEWEN</b> Address <b>HAGERSTOWN MD.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>1 1/2 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 12</b> , 19 <b>58</b> , to <b>Jan 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 18</b> , 19 <b>57</b> , and that death occurred at <b>2 30 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St.</b> DATE SIGNED <b>1/21/57</b> ACTUAL SIGNATURE <b>Philip J. Hirshman</b> M.D. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/22/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Norment, Hagerstown, Md.</b>		23. REC'D BY REGISTRAR <b>Jan 23, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1193

CERTIFICATE OF DEATH

01153

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAN MAR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRNEY-KEEDY MEMORIAL HOME</u>				d. STREET ADDRESS <u>06X22</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ENIMA CATHERINE McLAUGHLIN</u>				4. DATE OF DEATH Month Day Year <u>JANUARY - 11 - 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-28-1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB J. VINGLING</u>				14. MOTHER'S MAIDEN NAME <u>ANNA D. CAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-3413</u>		17. INFORMANT <u>RECORDS - FAIRNEY KEEDY MEMORIAL HOME</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of pancreas.</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 2</u> , 19 <u>56</u> , to <u>Jan 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 11</u> , 19 <u>57</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/12/57</u> ACTUAL SIGNATURE <u>G. W. Sullivan</u> M.D. <u>Boonshon</u> PHYSICIAN'S NAME (Type) <u>G. W. Sullivan</u> <u>Ind</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY CARROLL CO. MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. BERRYMAN AND SON</u> ADDRESS <u>REISTERSTOWN MD.</u>				24a. REC'D BY REGISTRAR <u>JAN 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Best</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		COUNTY [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		SEX [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1194

## CERTIFICATE OF DEATH

01154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>52 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. #1</b>		d. STREET ADDRESS <b>1 RFD #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Jay</b> Middle <b>Omer</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>28,</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1884</b>
9. AGE (In years lost birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Greensburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John P. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Susan R. Harbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-28-6563</b>	
17. INFORMANT <b>Abbie H. Miller, Smithsburg Rd 1, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized metastatic carcinoma</b> DUE TO (c) <b>6 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/9</b> , 19 <b>54</b> , to <b>1/28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/28/57</b> , 19 <b>57</b> , and that death occurred at <b>2:50 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1/29/57</b>			
ACTUAL SIGNATURE <b>Charles F. Hess M.D.</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>		<b>N. Main St., Smithsburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-30-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Church</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg RD #1, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 31 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Overseer</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01155

Reg. Dist. No. 302

1151

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>676 Pennsylvania Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>676 Pennsylvania Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KAREN</b> Middle <b>ANN</b> Last <b>MISNER</b>		4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12, 1956</b>
9. AGE (In years last birthday) <b>3</b> yrs. <b>3</b> Months <b>29</b> Days		10. IF UNDER 1 YEAR <b>3</b> Months <b>29</b> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lester D. Misner</b>		14. MOTHER'S MAIDEN NAME <b>Marie C. Jolliffe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Lester D. Misner</b>		Address <b>676 Pennsylvania Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation due to aspiration of vomitus</b> 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>None</b> (a), stating the underlying cause last. DUE TO (c) <b>None</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Sleeping on face and weighed down with bed clothing</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:00 p.m. Jan. 11, 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash Md</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>1-12-57</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/14/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc., Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 13, 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
JAN 15 1957  
BUREAU K. 3

1152

## CERTIFICATE OF DEATH

01156

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>VINCENT</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April, 1877</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tennant</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Mc Cra</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-9818</u>	
17. INFORMANT <u>Mrs. Frances Widmeyer Willamsport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Atherosclerotic heart disease</u> DUE TO (b) <u>cardiac decompensation</u> DUE TO (c) <u>Hypertensive vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2-4 mos.</u> <u>4-6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20, 1957</u> , to <u>Jan 22, 1957</u> , that I last saw the deceased alive on <u>Jan 22, 1957</u> , and that death occurred at <u>2:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>1/28/57</u>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>217 W. Washington St. Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/30/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Kouzer Funeral Home</u>		24. REC'D BY REGISTRAR <u>Jan. 29, 1957</u>	
ADDRESS <u>Hagerstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1195

11157  
0457  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Md</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Hancock Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>West Main St Hancock Md</b>				d. STREET ADDRESS <b>W. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jesse</b> Middle <b>Hager</b> Last <b>Murray</b>				4. DATE OF DEATH Month <b>1</b> Day <b>17</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10.29.1895</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph H Murray</b>				14. MOTHER'S MAIDEN NAME <b>Rose W Hurdle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Marvin K Murray W. Main St. Hancock Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Arteriosclerotic myocradial heart disease with failure grade iv</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Honard J. Stone Hancock Md</b>				24a. REC'D BY REGISTRAR <b>DATE 2/21/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. A. Wells</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		35		M		W		FEB 5 1957		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
NEW YORK		NEW YORK		HEART DISEASE		NATURAL		NEW YORK		FEB 6 1957	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED		DATE	
FEB 5 1922		NEW YORK		HIGH SCHOOL		MARRIED		J. M. JONES		FEB 6 1957	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
FEB 5 1957		NEW YORK		HEART DISEASE		NATURAL		NEW YORK		FEB 6 1957	

BUREAU V. B.

FEB 6 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1153

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Myersville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital			d. STREET ADDRESS Route # 2 10x12		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES SHERIDAN MYERS			4. DATE OF DEATH Month Day Year January 18 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1867 89 yrs.		9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farm	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Noah Myers			14. MOTHER'S MAIDEN NAME Mary Elizabeth Michael		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address O.L. Myers, Myersville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Cerebral Arterial Thrombosis DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 wk unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 19 55, to 1/18 19 57, that I last saw the deceased alive on 1/14 19 57, and that death occurred at 1:53 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Kenneth E. Henson		M.D. Middletown, Md.		DATE SIGNED 1/18/57	
PHYSICIAN'S NAME (Type) Kenneth E. Henson		Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/20/1957	22c. NAME OF CEMETERY OR CREMATORY United Brethern		22d. LOCATION (City, town, or county) (State) Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.		24. REC'D BY REGISTRAR Jan. 21, 1957	
				24b. REGISTRAR'S SIGNATURE Blas H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Age, Sex, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The form is mostly blank with some faint markings.

*General Medical Certificate*  
*General Medical Certificate*

BUREAU V. 1

JAN 23 1957

RECEIVED

*1/23/57*  
*1/23/57*  
*1/23/57*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG210 2-13-57 et

1154

CERTIFICATE OF DEATH

Reg. Dist. No.

01159

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Dubal</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean Way Fla. 48X-3</b>		d. STREET ADDRESS <b>12345 Main Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Delsie</b> Middle <b>Mae Kirby</b> Last <b>Nally</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 6 1905</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>24</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Kirby</b>		14. MOTHER'S MAIDEN NAME <b>Ella May</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Mr. William R. Nally</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma uteri ectocervix</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/23/57</b> , 19 <b>57</b> , to <b>1/30/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/30/57</b> , 19 <b>57</b> , and that death occurred at <b>6:43 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph F. Young</b> M.D.		DATE SIGNED <b>1/31/57</b>	
PHYSICIAN'S NAME (Type) <b>Ralph F. Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 2-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert S. Leaf Williamsport, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 4, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

## CERTIFICATE OF DEATH

BUREAU V. 2

FEB 6 1957

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		1921		Memphis, Tenn.	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
4/4/68		10:00 AM		St. Louis, Mo.		Suicide		Homicide			
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01160

1155

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY WASHINGTON MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 7 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 44 ALEXANDER ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last JESSE A. ORTT		<b>4. DATE OF DEATH</b> Month Day Year I 6 19 58	
<b>5. SEX</b> MALE	<b>6. COLOR OR RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> JUNE 6, 1877
<b>9. AGE</b> (In years last birthday) 79 yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) CIGAR MAKER		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> TOBACCO	
<b>11. BIRTHPLACE</b> (State or foreign country) PENNA.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.	
<b>13. FATHER'S NAME</b> JOHN ORTT		<b>14. MOTHER'S MAIDEN NAME</b> LOUISE WELTY	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) NO		<b>16. SOCIAL SECURITY NO.</b> I68-I4-2486	
<b>17. INFORMANT</b> ETZWEILER FUNERAL HOME		<b>Address</b> YORK, PENNA.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable partial intestinal obstruction		INTERVAL BETWEEN ONSET AND DEATH 15 min 15 yr	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from Jan 5, 1957, to Jan 6, 1957, that I last saw the deceased alive on Jan 5, 1957, and that death occurred at 10:15 P.M. from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> Edmund W. O'Dell III M.D.		<b>ADDRESS</b> (Street, city or town, state) 212 W. Washington St.	
<b>PHYSICIAN'S NAME</b> (Type) FRED W. KRAISS		<b>DATE SIGNED</b> 1/6/57	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) BURIAL		<b>22b. DATE THEREOF</b> 1/9/57	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> PROSPECT HILL		<b>22d. LOCATION</b> (City, town, or county) (State) YORK PENNA.	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> FRED W. KRAISS		<b>24. REC'D BY REGISTRAR</b> Jan 8. 1957	
<b>24b. REGISTRAR'S SIGNATURE</b> Chas. H. Bowers			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG209 1-18-57 et

CERTIFICATE OF DEATH

01161

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>Adele</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmistress</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U. S. POSTOFFICE</u>	
11c. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Foster Mongan</u>		14. MOTHER'S MAIDEN NAME <u>Martha Lucinda Jamison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Edwin C. Palmer</u>		Address <u>Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent carcinoma of right breast with</u> <u>170X</u> DUE TO generalized metastases of chest & medias tinum. (b) <u>Carcinoma of the right breast</u> DUE TO 5 years (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1/56</u> , 19 <u>56</u> , to <u>Jan. 9</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/8/57</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u> DATE SIGNED <u>1/12/57</u>			
ACTUAL SIGNATURE <u>Walter H. Shealy</u>		M.D. <u>Sharpsburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Leaf</u>		24a. REC'D BY REGISTRAR <u>Jan. 14 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			





# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01162

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Several Hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md. x2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dead on arrival Washington Co Hosp</b>				d. STREET ADDRESS <b>153 N. Artizan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Alexander</b> Last <b>Palmer</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 27 1913</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adam Palmer</b>				14. MOTHER'S MAIDEN NAME <b>Eve Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World War #2060-14-4668</b>		17. INFORMANT <b>Mrs. Hazel Palmer Williamsport Md.</b>		Address <b>153 N. Artizan</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary Occlusion</b></p> <p><b>420.1</b> DUE TO <b>Vascular Hypertension</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____</p> <p>(c) _____</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>SAMUEL ROBERT WELLS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Leaf Williamsport Md</b>				24a. REC'D BY REGISTRAR <b>Jan. 22, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Black Bowers</b>	

RECEIVED

JAN 24 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

1. I have examined the body of the deceased and find that the cause of death is [illegible].  
2. I have examined the records of the deceased and find that the cause of death is [illegible].  
3. I have examined the records of the deceased and find that the cause of death is [illegible].  
4. I have examined the records of the deceased and find that the cause of death is [illegible].  
5. I have examined the records of the deceased and find that the cause of death is [illegible].  
6. I have examined the records of the deceased and find that the cause of death is [illegible].  
7. I have examined the records of the deceased and find that the cause of death is [illegible].  
8. I have examined the records of the deceased and find that the cause of death is [illegible].  
9. I have examined the records of the deceased and find that the cause of death is [illegible].  
10. I have examined the records of the deceased and find that the cause of death is [illegible].

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01163

1158

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>507 Jefferson Street</b>				d. STREET ADDRESS <b>1 507 Jefferson Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>AUTENZIO</b> Last <b>PAPA</b>				4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1880</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Gabriel Autenzio</b>				14. MOTHER'S MAIDEN NAME <b>Teresa Tomaso</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Frank Papa</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x</b> DUE TO <b>arterio-sclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes</b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-1-56</b> , 19____, to <b>1-21-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-16-57</b> , 19____, and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. E. W. Outh</b>				ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>1/24/57</b>			
PHYSICIAN'S NAME (Type) <b>DREW HITT</b>				DATE SIGNED <b>1-24-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/24/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Boyer</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Jan. 26, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Powers</b>			

RECEIVED

1159

## CERTIFICATE OF DEATH

01164

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
c. LENGTH OF STAY IN 1b 41 years		d. STREET ADDRESS 108 E. Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lulu Elizabeth Paynter		4. DATE OF DEATH Month Day Year 1 22 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Point of Rocks, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert R. Rutherford		14. MOTHER'S MAIDEN NAME Louise Sealock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles S. Paynter		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rhumatic heart disease with multiple valvular defects. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years indeterminate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Chronic myelogenous leukemia		17 years duration	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 25, 1956, to Jan. 22, 1957, that I last saw the deceased alive on Jan. 22, 1957, and that death occurred at 1:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED	
M.D. 100 Professional Arts. Bldg. 1-23-57			
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-25-57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Jan. 24, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



JAN 28 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1196

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Fulton</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conococheague Md</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <u>Salway Conv. Home</u>				d. STREET ADDRESS <u>75X-3 None</u>			
3. NAME OF DECEASED (Type or print) <u>Julia Irene Peck</u>				4. DATE OF DEATH <u>Jan 23, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 19, 1880</u>	
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		IF UNDER 1 YEAR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Big Cove Tannery, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Pittman</u>				14. MOTHER'S MAIDEN NAME <u>Emaline Mellett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>184-12-4548</u>		17. INFORMANT <u>J. C. Peck</u> Address <u>McConnellsburg Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Sclerotic Endocarditis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Nov. 29, 1954</u> to <u>Jan 23, 1957</u> that I last saw the deceased alive on <u>Jan 23, 1957</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.				ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>1/23/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Brewer M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 26, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rehobeth</u>		22d. LOCATION (City, town, or county) (State) <u>Thompson Twp. Fulton Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Gunning</u> ADDRESS <u>McConnellsburg, Pa.</u>				24a. REC'D BY REGISTRAR <u>Jan 29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Leroy M. Fochler</u> (Deputy)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01166

Reg. Dist. No. 302

<b>1160</b> <b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>-</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>																
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Enroute to Hospital</u>					d. STREET ADDRESS <u>674 Highland Way</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>F</u> Last <u>Pike</u>				<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>14</u> Year <u>19 57</u>																	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 28, 1884</u>		9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stone Mason</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin County, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>												
13. FATHER'S NAME <u>Oliver Pike</u>					14. MOTHER'S MAIDEN NAME <u>Martha Zegar</u>																
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>185-07-5582</u>		17. INFORMANT Address <u>Mr. John Pike- 200 Garlinger Ave-Hagerstown</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis</u> DUE TO <u>arteriosclerotic myocardial heart disease</u> (b) <u>Acute ventricular fibrillation</u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hay Fever &amp; Asthma</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>																	
20c. TIME OF INJURY Month, Day, Year <u>none 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>-</u>		(County) <u>-</u>		(State) <u>-</u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>S. Robert Wells</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED											
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					<u>1-14-57</u>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									22b. DATE THEREOF <u>1/18/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Greencastle, Adams Twp. Penna.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald M. Zimmerman</u>						ADDRESS <u>Greencastle, Pa.</u>						REC'D BY REGISTRAR <u>JAN. 17. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. A. K. Bowers</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the records of the State Department of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED



1161  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul Woodrow</u> <u>PITTMAN</u>				4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>2</u> <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1913</u>		9. AGE (In years lost birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Russell Pittman</u>				14. MOTHER'S MAIDEN NAME <u>Ada Hawbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>183-12-3684</u>		17. INFORMANT Address <u>Wife- Martha T. Pittman, Big Pool, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma metastases to the pelvis</u> 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sarcoma of the right leg</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>about 8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 18</u> , 19 <u>56</u> , to <u>Dec. 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 31</u> , 19 <u>56</u> , and that death occurred at <u>3:42 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>J. Walter Layman</u> M.D. <u>100 Professional Arts Bldg., 1/3/57</u> PHYSICIAN'S NAME (Type) <u>J. Walter Layman, M. D., Hagerstown, Maryland.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MERCERSBURG PA. R.#1</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Luning</u> ADDRESS <u>Mercersburg, Pa.</u>				24a. REC'D BY REGISTRAR <u>Jan 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Brown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. F.

BUREAU V. F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01168

1162

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>68 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>50 S. Cannon Ave.</b>		d. STREET ADDRESS <b>50 S. Cannon Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Leila</b> First <b>Lucretia</b> Middle <b>Rodgers</b> Last		4. DATE OF DEATH <b>January 14 1957</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1882</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Near Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Otho James</b>		14. MOTHER'S MAIDEN NAME <b>Alice C. Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>John F. Rodgers</b> Address <b>Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>199.9</b> IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/12/57</b> to <b>1/14/57</b> , that I last saw the deceased alive on <b>1/14/57</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>1/15/57</b>			
ACTUAL SIGNATURE <b>D. J. Boyer</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>Jan. 18. 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Chas. C. Bowers</b>	

BUREAU V. S.

JAN 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										01169
CERTIFICATE OF DEATH										Reg. Dist. No. 303
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>1197</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>					d. STREET ADDRESS <b>1 436 Jefferson St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>BRANNON</b> Middle <b>BARZELLA</b> Last <b>ROGERS</b>					4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>19 57</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1872</b>		9. AGE (In years last birthday) <b>84</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rubber Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Casper Rogers</b>					14. MOTHER'S MAIDEN NAME <b>Martha Ann Chrisman</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-3842A</b>		17. INFORMANT <b>Mrs. Hazel B. Rogers</b> <b>436 Jefferson St. Hagerstown, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with myocardial failure grade 4</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____									INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>July 18, 19 56</b> , to <b>Nov. 23, 19 56</b> , that I last saw the deceased alive on <b>November 23, 19 56</b> , and that death occurred at <b>6:45 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac Street 1-28-57 Hagerstown, Maryland.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>R. A. Bell</b> M.D. PHYSICIAN'S NAME (Type) <b>R. A. Bell.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Long Meadow Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hagerstown R #6 Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>					24a. REC'D BY REGISTRAR <b>Jan 30 57</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fickler</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		JAN 12, 1957		JAMES H. HARRIS	
AGE		SEX		RACE	
65		M		W	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 1, 1892		JAMES H. HARRIS		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		FARMER	
PREVIOUS DEATH		CAUSE OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		NATURAL	
DATE OF BURIAL		PLACE OF BURIAL		CEREMONY	
JAN 15, 1957		JAMES H. HARRIS		NONE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 12, 1957		JAN 12, 1957		JAN 12, 1957	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 12, 1957		JAN 12, 1957		JAN 12, 1957	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 3

FEB 4 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01170

1163

CERTIFICATE OF DEATH

Dr Hornbaker

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		e. STREET ADDRESS <b>1903 Virginia Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>MATTIE</b> Middle <b>EAKLE</b> Last <b>ROWLAND</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 29 1883</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willis W. Eakle</b>		14. MOTHER'S MAIDEN NAME <b>Ida F. Warrenfeltz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harvey P. Rowland</b>		Address <b>1903 Virginia Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x</b> DUE TO <b>Pulmonary embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombophlebitis, left leg</b> (c) <b>Hypertensive cardiovascular disease with congestive failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min - 8 days - ? 4 hrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/31, 1942</b> , to <b>1-19, 1957</b> , that I last saw the deceased alive on <b>1/19, 1957</b> , and that death occurred at <b>10:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John H. Hornbaker</b>		ADDRESS (Street, city or town, state) <b>154 West Washington Street, Hagerstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		DATE SIGNED <b>1-21-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/22/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24. REC'D BY REGISTRAR <b>Jan. 22, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Shirley Bowers</b>	

RECEIVED

1164

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>520 Washington Square</b>			d. STREET ADDRESS <b>520 Washington Square</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Jane</b> Last <b>Rubeck</b>			4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>19 57</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 12, 1872</b>		9. AGE (In years lost birthday) <b>85</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Mercersburg, Pa.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Simon Shaffer</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Mary A. Swartz</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-3-57</b> , 19 <b>57</b> , to <b>1-18-57</b> , that I last saw the deceased alive on <b>1-12-57</b> , 19 <b>57</b> , and that death occurred at <b>3:30 A.</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>[Signature]</b>			ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>1/18/57</b>		
PHYSICIAN'S NAME (Type) <b>[Signature]</b>			DATE SIGNED <b>1/18/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan. 22, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13119

1165

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>			d. STREET ADDRESS <u>/R.F.D. # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle <u>WESLEY</u> Last <u>RUDISILL</u>			4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 23, 1905</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Millwright</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Company</u>		11. BIRTHPLACE (State or foreign country) <u>Smithsburg, Md.</u>	
13. FATHER'S NAME <u>George Rudisill</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>214-09-1953</u>		
17. INFORMANT <u>Mrs. Yuba M. Rudisill Hagerstown, Md.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiomegaly disease</u> DUE TO (c) <u>congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years (?)</u> <u>6 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>6-21, 1939</u> , to <u>1-12-9, 1957</u> , that I last saw the deceased alive on <u>1-12-9, 1957</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D. <u>154 West Washington St.,</u> <u>1:10:57</u> PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u> <u>Hagerstown, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Royce</u>		ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 10, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Thos. H. Bowers</u>					

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		M		45		JAN 15 1912		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
MARRIED		WIDOWED		DIVORCED		SINGLE		MARRIED		WIDOWED		DIVORCED		SINGLE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 14 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 14 1957		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH	
HEART DISEASE		NATURAL		JAN 14 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 14 1957	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JAN 14 1957		NEW YORK		NEW YORK		NEW YORK		UNITED STATES		JAN 14 1957		NEW YORK		NEW YORK	

BUREAU V. S.

JAN 14 1957

RECEIVED

1166 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01172

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>				d. STREET ADDRESS <u>1205 Potomac Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ODA</u> Middle <u>LOUISE</u> Last <u>SCHARF</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1885</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>26</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Operator</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jacob Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Louise Gaver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss. Louise Sutter Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>4 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>50</u> , to <u>Jan. 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 25</u> , 19 <u>57</u> , and that death occurred at <u>5:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>1/26/57</u> ACTUAL SIGNATURE <u>Oloyd A. Hoffman</u> PHYSICIAN'S NAME (Type) <u>Oloyd A. Hoffman</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/28/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 29. 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

BUREAU V. S.

FEB 1 1957

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1167 CERTIFICATE OF DEATH

01173

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		STATE <u>Maryland</u>		COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u>		LENGTH OF STAY (in this place) <u>2 WKS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>				STREET ADDRESS (If rural give location) <u>122 E. Main St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Earl William Shoemaker</u>				<b>4. DATE OF DEATH</b> (Month) <u>1</u> (Day) <u>20</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17, 1912</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if done during most of working life, even if) <u>Sand Dryer Operator Sand Mines</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sand Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Shoemaker</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Shives</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-8591</u>		17. INFORMANT & ADDRESS <u>Virginia M Shoemaker Hancock Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1 IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure with Hydrothorax</u>						<u>15 days</u>	
2 ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>4 years</u>	
3 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive cardiovascular renal disease</u>						<u>4 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonitis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-5-57</u> , 19 <u>57</u> , to <u>1-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>57</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>Hagerstown, Maryland</u>		ADDRESS (Street, city, town, state) <u>100 Professional Arts Bldg.</u>		DATE SIGNED <u>1-23-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1.24.57</u>		NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 28, 1957</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Hancock Md.</u>	



RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1168

## CERTIFICATE OF DEATH

Reg. Dist. No.

01174

<b>1. PLACE OF DEATH</b> o. COUNTY <u>Washington</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Big Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Howard</u> Last <u>Smith</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>14</u> Year <u>1957</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 20, 1876</u>	
<b>9. AGE</b> (In years last birthday) <u>80</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Grain Elevator</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Big Spring, Md.</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>William E. Smith</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Mc Laughlin</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs Ada V. Smith</u>		<b>Address</b> <u>Big Spring, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gremia</u> <u>456x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis obliterans</u> DUE TO (c) _____						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u> <u>54 years?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial pneumonia</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I attended the deceased from</b> <u>12/31</u> , 19 <u>56</u> , to <u>1/14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14</u> , 19 <u>57</u> , and that death occurred at <u>330p</u> M, from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>George Jennings</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>136 W. Washington St</u>			
<b>DATE SIGNED</b> <u>1/15/57</u>							
<b>PHYSICIAN'S NAME</b> (Type) <u>George Jennings</u>				<u>Hagerstown, Md</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Jan. 17, 1957</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Clear Spring, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John F. Clark</u>				<b>ADDRESS</b> <u>Clear Spring, Md.</u>		<b>24. REC'D BY REGISTRAR</b> <u>Jan. 17, 1957</u>	
				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Phyllis H. Bowers</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. 21

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1169

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

01175

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place) <u>3 WKS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>139 High St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Marjorie</u>		(Middle) <u>Alice</u>		(Last) <u>Smith</u>		(Month) <u>1</u> (Day) <u>28</u> (Year) <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 7. 1915</u>	9. AGE last birthday <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Fling</u>				14. MOTHER'S MAIDEN NAME <u>Olive Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sodd W Smith 139 High St. Hancock Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
5020 IMMEDIATE CAUSE (A) <u>Congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks ?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic bronchitis &amp; emphysema</u>				<u>6 yrs ?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic right heart strain (Chronic Cor Pulmonale)</u>				<u>Unknown</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-9-57</u> , to <u>1-28-57</u> , that I last saw the deceased alive on <u>1-28-57</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Hager</u>				ADDRESS (Street, city, town, state) <u>154 West Washington St., M.D. Hagerstown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>2.2.57</u>		NAME OF CEMETERY OR CREMATORY <u>Buckvalley Cemetery</u>	
24. REC'D BY REGISTRAR <u>Feb. 5. 1957</u>		REGISTRAR'S SIGNATURE <u>Shad H. Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Shaw</u>		ADDRESS <u>Hancock Md</u>	
						LOCATION (City, town, or county) (State) <u>Buckvalley Fulton Penna.</u>	

6250

BUREAU V. S.

FEB 7 1957

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## CERTIFICATE OF DEATH

01176

Reg. Dist. No.

302

1170

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Myers</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>1</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1886</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>main. man Masonic Temple</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>718-12-6977</b>	
17. INFORMANT <b>Mrs. Mary Smith</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>585X</b> DUE TO (b) <b>Acute Cholecystitis</b> DUE TO (c) <b>Chronic Myocarditis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.2</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-20-</b> , 19 <b>57</b> , to <b>1-24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1-23-57</b> , 19 <b>57</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. Smith</b> M.D.		ADDRESS (Street-city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>1/25/57</b>	
PHYSICIAN'S NAME (Type) <b>FRED W. KRAISS</b>		DATE SIGNED <b>1/25/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Jan. 28, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Powers</b>	

after death: Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be retained by the hospital or attending physician. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		12-1-27		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PRESENT ADDRESS		18. PREVIOUS ADDRESS		19. PRESENT ADDRESS		20. PREVIOUS ADDRESS		21. PRESENT ADDRESS		22. PREVIOUS ADDRESS		23. PRESENT ADDRESS		24. PREVIOUS ADDRESS	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.		MEMPHIS, TENN.	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF DECEASED		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF DECEASED		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF DECEASED		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF DECEASED		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 3

JAN 30 1967

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

01177  
30277

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>211 Jefferson St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bertha Grace Snyder</b>		4. DATE OF DEATH <b>January 29 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1887</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Shippensburg Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Shamberger</b>		14. MOTHER'S MAIDEN NAME <b>Martha Lutz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>420.0</b>	
17. INFORMANT <b>Mrs. Margaret Lewis</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis, General</b>			INTERVAL BETWEEN ONSET AND DEATH <b>23 days</b> <b>4 yrs.</b> <b>4 yrs.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 8</b> , 19 <b>49</b> , to <b>Jan 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Jan 29</b> , 19 <b>57</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		DATE SIGNED <b>1/29/57</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		159 W. Washington St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-31-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>Feb. 1, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 4 1957

BUREAU V. B.

**BUREAU V. S.**

FEB 4 1957

RECEIVED

1172

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		d. STREET ADDRESS <b>68 Winter St.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Cora</b> Last <b>Socks</b>		4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1884</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR: Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Earhart</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-09-9413</b>	
17. INFORMANT <b>Edgar Socks</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> , to <b>Jan 31, 1957</b> , that I last saw the deceased alive on <b>30 Jan</b> , 1957, and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. Edmon R. Hoachlander</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>ELLON G. HOACHLANDER, M.D. 2/1/57</b> <b>115 W. WASHINGTON STREET</b> <b>HAGERSTOWN, MARYLAND</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>2-3-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>Feb 6, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1173

## CERTIFICATE OF DEATH

Reg. Dist. No.

01179  
303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Hulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nagerstown Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McCannellsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Conv. Home</u>		d. STREET ADDRESS <u>E. Lincoln Way</u>	
3. NAME OF DECEASED (Type or print) <u>Franklin</u> First <u>Kirk</u> Middle <u>Stevens</u> Last		4. DATE OF DEATH <u>January 16</u> 19 <u>57</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Hulton Co. Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph D. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>George A. Paul</u> Address <u>McCannellsburg Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 3</u> , 19 <u>55</u> , to <u>Jan 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 15</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>1/17/57</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>McCannellsburg Hulton Co. Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. McCall</u> ADDRESS <u>McCannellsburg Pa.</u>		24a. REC'D BY REGISTRAR <u>Jan 23-57</u>	24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1174

## CERTIFICATE OF DEATH

01180

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75x-3 Rural Greencastle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Route #3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry W.</u> Middle <u>Stickell</u> Last <u>Stickell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plaster Contractor</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Stickell</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Wolfe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unable to obtain</u>	
17. INFORMANT <u>Mr. Earl Shickel</u> Address <u>Route #3 Greencastle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260X Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-20-1957</u> , to <u>1-21-1957</u> , that I last saw the deceased alive on <u>1-21-1957</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.		ADDRESS (Street, city or town, state) <u>154 West Washington Street</u> DATE SIGNED <u>1:23:57</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		<u>Hagerstown, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/25/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Montgomery Church Co</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery Twp Franklin Co. Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u> ADDRESS <u>Greencastle Pa</u>		24. REC'D BY REGISTRAR <u>Jan. 26, 1957</u>	25. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>

RECEIVED



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01181

1175

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>8 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1127 KUHN AVE. EXT.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>STOUFFER</b> Last <b>STOUFFER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/29/1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TENNANT FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL STOUFFER</b>		14. MOTHER'S MAIDEN NAME <b>JANE HOUCK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-30-7152</b>	
17. INFORMANT <b>MRS. KATIE V. STOUFFER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b> DUE TO <b>Carcinoma Prostate</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1 year</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-1-1936</b> , to <b>1-17-1957</b> , that I last saw the deceased alive on <b>1-16-57</b> , 19____, and that death occurred at <b>5 A. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. E. Smith</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b> DATE SIGNED <b>1/18/57</b>	
PHYSICIAN'S NAME (Type) <b>S. E. Smith</b>		<b>Hagerstown Md</b> <b>1/18/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SMITHSBURG CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>SMITHSBURG MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>		24. REC'D BY REGISTRAR <b>Jan. 21, 1957</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>	

RECEIVED  
JAN 23 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01182

1176

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hubert</u> Middle <u>Elwood</u> Last <u>Stover</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1887</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. A. Stickell</u>	
11. BIRTHPLACE (State or foreign country) <u>Monroe, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albertus Stover</u>		14. MOTHER'S MAIDEN NAME <u>Martha Danner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-6231</u>	
17. INFORMANT <u>Mrs. Daisy Burgess</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic myocardial heart disease</u> DUE TO <u>acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial asthma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, <u>  </u> Day, <u>19</u> Year <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>Jan. 1, 1945</u> , to <u>Jan. 1, 1957</u> , that I last saw the deceased alive on <u>Jan. 1, 1957</u> , and that death occurred at <u>8:25 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		DATE SIGNED <u>115 N. Potomac Street</u>	
PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manor</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghmanton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>		ADDRESS <u>Hagerstown, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 4. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

# CERTIFICATE OF DEATH

Form 100-100

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]	
6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR OF HAIR [REDACTED]		9. COLOR OF EYES [REDACTED]		10. COLOR OF SKIN [REDACTED]	
11. CAUSE OF DEATH [REDACTED]		12. MANNER OF DEATH [REDACTED]		13. PLACE OF DEATH [REDACTED]		14. DATE OF DEATH [REDACTED]		15. TIME OF DEATH [REDACTED]	
16. SIGNATURE OF DECEASED [REDACTED]		17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF PHYSICIAN [REDACTED]		19. SIGNATURE OF CORONER [REDACTED]		20. SIGNATURE OF JURY [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]		23. SIGNATURE OF PHYSICIAN [REDACTED]		24. SIGNATURE OF CORONER [REDACTED]		25. SIGNATURE OF JURY [REDACTED]	
26. SIGNATURE OF DECEASED [REDACTED]		27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF PHYSICIAN [REDACTED]		29. SIGNATURE OF CORONER [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]		33. SIGNATURE OF PHYSICIAN [REDACTED]		34. SIGNATURE OF CORONER [REDACTED]		35. SIGNATURE OF JURY [REDACTED]	
36. SIGNATURE OF DECEASED [REDACTED]		37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF PHYSICIAN [REDACTED]		39. SIGNATURE OF CORONER [REDACTED]		40. SIGNATURE OF JURY [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]		43. SIGNATURE OF PHYSICIAN [REDACTED]		44. SIGNATURE OF CORONER [REDACTED]		45. SIGNATURE OF JURY [REDACTED]	
46. SIGNATURE OF DECEASED [REDACTED]		47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF PHYSICIAN [REDACTED]		49. SIGNATURE OF CORONER [REDACTED]		50. SIGNATURE OF JURY [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]		53. SIGNATURE OF PHYSICIAN [REDACTED]		54. SIGNATURE OF CORONER [REDACTED]		55. SIGNATURE OF JURY [REDACTED]	
56. SIGNATURE OF DECEASED [REDACTED]		57. SIGNATURE OF WITNESS [REDACTED]		58. SIGNATURE OF PHYSICIAN [REDACTED]		59. SIGNATURE OF CORONER [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]		63. SIGNATURE OF PHYSICIAN [REDACTED]		64. SIGNATURE OF CORONER [REDACTED]		65. SIGNATURE OF JURY [REDACTED]	
66. SIGNATURE OF DECEASED [REDACTED]		67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF PHYSICIAN [REDACTED]		69. SIGNATURE OF CORONER [REDACTED]		70. SIGNATURE OF JURY [REDACTED]	
71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]		73. SIGNATURE OF PHYSICIAN [REDACTED]		74. SIGNATURE OF CORONER [REDACTED]		75. SIGNATURE OF JURY [REDACTED]	
76. SIGNATURE OF DECEASED [REDACTED]		77. SIGNATURE OF WITNESS [REDACTED]		78. SIGNATURE OF PHYSICIAN [REDACTED]		79. SIGNATURE OF CORONER [REDACTED]		80. SIGNATURE OF JURY [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]		83. SIGNATURE OF PHYSICIAN [REDACTED]		84. SIGNATURE OF CORONER [REDACTED]		85. SIGNATURE OF JURY [REDACTED]	
86. SIGNATURE OF DECEASED [REDACTED]		87. SIGNATURE OF WITNESS [REDACTED]		88. SIGNATURE OF PHYSICIAN [REDACTED]		89. SIGNATURE OF CORONER [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]		93. SIGNATURE OF PHYSICIAN [REDACTED]		94. SIGNATURE OF CORONER [REDACTED]		95. SIGNATURE OF JURY [REDACTED]	
96. SIGNATURE OF DECEASED [REDACTED]		97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF PHYSICIAN [REDACTED]		99. SIGNATURE OF CORONER [REDACTED]		100. SIGNATURE OF JURY [REDACTED]	

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1177

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Rest Home, 1223 Virginia Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>S.</b> Last <b>Sturdevant</b>				4. DATE OF DEATH Month <b>1</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5, 1889?</b>	9. AGE (In years last birthday) <b>67?</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Faichild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Lantz, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Calvin J. Sturdevant</b>				14. MOTHER'S MAIDEN NAME <b>Florence Bingham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-10-3563</b>		17. INFORMANT <b>Mrs. Melvin Brown</b> Address <b>204 Homewood Ave. Waynesboro, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x Generalized arteriosclerosis</b> DUE TO <b>cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2-3 yrs</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive vascular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 3, 1956</b> , to <b>Jan 11, 1957</b> , that I last saw the deceased alive on <b>Jan 10, 1957</b> , and that death occurred at <b>12:30 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>1/11/57</b>			
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M. D.</b> <b>217 W. Washington St. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>		22d. LOCATION (City, town, or county) (State) <b>Lantz, Md. R.D.1</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Gure</b> ADDRESS <b>Waynesboro, Pa.</b>				24. REC'D BY REGISTRAR <b>Jan. 14, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Rogers</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DEPARTMENT OF HEALTH BALTIMORE, MD.		COUNTY OF _____ CITY OF _____	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
DATE OF DEATH _____		PLACE OF DEATH _____	
TIME OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		AGED _____	
OCCUPATION _____		EDUCATION _____	
BIRTH DATE _____		BIRTH PLACE _____	
PARENTS FATHER: _____ MOTHER: _____		SPOUSE _____	
CHILDREN _____		OTHER RELATIVES _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF CORONER _____	
SIGNATURE OF JURY _____		SIGNATURE OF JUDGE _____	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01184

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1178

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 18 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Nursing Home		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First CLAUDIA Middle MAY Last VANSANT		4. DATE OF DEATH Month 1-23- Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1869
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Norvel Hobbs		14. MOTHER'S MAIDEN NAME Josephine Gilbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident & Pyogenic infection DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior disease of heart DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956, to Jan 1957, that I last saw the deceased alive on 1/23/57, 1957, and that death occurred at 8 p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Howard N. Weeks M.D.		136 N. Calverton Hagerstown Md. 1/24/57	
PHYSICIAN'S NAME (Type) HOWARD N. WEEKS		HAGERSTOWN MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-26-1957	
22c. NAME OF CEMETERY OR CREMATORY Prospect		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE 1 JAN 28 1957	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01185

1179

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVELYN</u> Middle <u>MARIE</u> Last <u>VIANDS</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 5, 1957</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Denzil E. Viands</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Mae Barr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
17. INFORMANT <u>Mr. Venzil E. Viands</u>		18. ADDRESS <u>337 Elizabeth Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity (6 mos.)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>57</u> , to <u>1/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>57</u> , and that death occurred at <u>5:20</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Ruben Hefner</u> M.D. <u>H. Potomac St.</u> PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>Jan. 7, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Blair H. Bowers</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARTIN		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH JAN 15 1912		5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. RACE WHITE		9. RELIGION METHODIST		10. EDUCATION HIGH SCHOOL		11. SOCIAL SECURITY NUMBER 1-123-456789		12. DATE OF DEATH JAN 10 1957	
13. PLACE OF DEATH HOME		14. CAUSE OF DEATH HEART DISEASE		15. MANNER OF DEATH NATURAL		16. MEDICAL HISTORY HYPERTENSION		17. PRESENT ILLNESS CORONARY THROMBOSIS		18. DATE OF ONSET JAN 5 1957	
19. SIGNATURE OF PHYSICIAN J. D. SMITH		20. SIGNATURE OF DECEASED MARTIN		21. SIGNATURE OF WITNESS J. D. SMITH		22. SIGNATURE OF DECEASED MARTIN		23. SIGNATURE OF WITNESS J. D. SMITH		24. SIGNATURE OF WITNESS J. D. SMITH	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01186

1198  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>44 W. Water St.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>	
3. NAME OF DECEASED (Type or print) First <b>Wade</b> Middle <b>Wenton</b> Last <b>Warrenfeltz</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>9,</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>lumber co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Warrenfeltz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Schroyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>215-18-2283</b>	
17. INFORMANT <b>Sadie E. Warrenfeltz, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo.</b> <b>5 Yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/18</b> , 19 <b>55</b> , to <b>1/8</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/5</b> , 19 <b>57</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>1/9/57</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b>		M.D. <b>Smithsburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Jan. 11, '57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>Jan 14 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Paul...</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN W. BARNES		DATE OF BIRTH JAN 10, 1893		PLACE OF BIRTH BALTIMORE, MD	
RACE WHITE		SEX MALE		MARRIAGE MARRIED	
EDUCATION HIGH SCHOOL		OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 14, 1957		PLACE OF DEATH BALTIMORE, MD		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. W. BARNES		SIGNATURE OF DECEASED JOHN W. BARNES		SIGNATURE OF WITNESSES J. W. BARNES	
DATE OF SIGNATURE JAN 14, 1957		DATE OF SIGNATURE JAN 14, 1957		DATE OF SIGNATURE JAN 14, 1957	

BUREAU V. S.

JAN 14 1957

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1180**  
**CERTIFICATE OF DEATH**

01187

Reg. Dist. No. **302**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>6 MO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>142 N. LOCUST ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LINCOLN WESTON</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 3 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/21/1891</b>	
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MACHINIST</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RADIO EQUIP. CO.</b>			
11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>WILLIAM WESTON</b>				14. MOTHER'S MAIDEN NAME <b>LUCY SAWER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>353-22-1707</b>			
17. INFORMANT Address <b>MRS. DOROTHY B. WESTON HAGERSTOWN MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Occlusion</b> <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema, Pulmonary</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 5, 1956</b> to <b>Nov. 17, 1956</b> , that I last saw the deceased alive on <b>Nov. 17, 1956</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>				DATE SIGNED <b>159 W. Washington St. Hagerstown Md. 1/16/57</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				<b>159 W. Washington St., Hagerstown, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. J. Norment</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>Jan 5, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU A. B.**

JAN 8 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01188

## CERTIFICATE OF DEATH

1199

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Washington</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hancock</u>		<u>Life</u>		TOWN <u>Hancock</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Home</u>				<u>108 Fairview Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Louise Reed Williams</u>				<u>1 28 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>B</u>	<u>Widowed</u>	<u>Aug. 12. 1870</u>	<u>86</u> yrs.	Months <u>6</u>	Days <u>16</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Maryland.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Reed</u>				<u>Victoria Jounker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs Kitty Moxley 108 Fairview Drive</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				<u>Chronic Myocarditis</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>arterio sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 27 1957</u> to <u>Jan 27 1957</u> , that I last saw the deceased alive on <u>Jan 27 1957</u> , and that death occurred at <u>2:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Smoker</u>				ADDRESS (Street, city, town, state) <u>Hancock, Md.</u>		DATE SIGNED <u>1/30/57</u>	
M.D. <u></u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1.30.57</u>		<u>Riverview Cemetery</u>		<u>Hancock Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1/30/57</u>		<u>La Neale</u>		<u>Hancock</u>		<u>Hancock Md</u>	



CERTIFICATE OF DEATH

Page 1 of 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. OCCUPATION

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. MANNER OF DEATH

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF WITNESS

22. SIGNATURE OF DECEASED

23. DATE OF DEATH

24. TIME OF DEATH

25. PLACE OF DEATH

26. CAUSE OF DEATH

27. MANNER OF DEATH

28. SIGNATURE OF PHYSICIAN

29. SIGNATURE OF WITNESS

30. SIGNATURE OF DECEASED

31. DATE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. CAUSE OF DEATH

35. MANNER OF DEATH

36. SIGNATURE OF PHYSICIAN

37. SIGNATURE OF WITNESS

38. SIGNATURE OF DECEASED

39. DATE OF DEATH

40. TIME OF DEATH

41. PLACE OF DEATH

42. CAUSE OF DEATH

43. MANNER OF DEATH

44. SIGNATURE OF PHYSICIAN

45. SIGNATURE OF WITNESS

46. SIGNATURE OF DECEASED

47. DATE OF DEATH

48. TIME OF DEATH

49. PLACE OF DEATH

50. CAUSE OF DEATH

51. MANNER OF DEATH

52. SIGNATURE OF PHYSICIAN

53. SIGNATURE OF WITNESS

54. SIGNATURE OF DECEASED

55. DATE OF DEATH

56. TIME OF DEATH

57. PLACE OF DEATH

58. CAUSE OF DEATH

59. MANNER OF DEATH

60. SIGNATURE OF PHYSICIAN

61. SIGNATURE OF WITNESS

62. SIGNATURE OF DECEASED

63. DATE OF DEATH

64. TIME OF DEATH

65. PLACE OF DEATH

66. CAUSE OF DEATH

67. MANNER OF DEATH

68. SIGNATURE OF PHYSICIAN

69. SIGNATURE OF WITNESS

70. SIGNATURE OF DECEASED

71. DATE OF DEATH

72. TIME OF DEATH

73. PLACE OF DEATH

74. CAUSE OF DEATH

75. MANNER OF DEATH

76. SIGNATURE OF PHYSICIAN

77. SIGNATURE OF WITNESS

78. SIGNATURE OF DECEASED

79. DATE OF DEATH

80. TIME OF DEATH

81. PLACE OF DEATH

82. CAUSE OF DEATH

83. MANNER OF DEATH

84. SIGNATURE OF PHYSICIAN

85. SIGNATURE OF WITNESS

86. SIGNATURE OF DECEASED

87. DATE OF DEATH

88. TIME OF DEATH

89. PLACE OF DEATH

90. CAUSE OF DEATH

91. MANNER OF DEATH

92. SIGNATURE OF PHYSICIAN

93. SIGNATURE OF WITNESS

94. SIGNATURE OF DECEASED

95. DATE OF DEATH

96. TIME OF DEATH

97. PLACE OF DEATH

98. CAUSE OF DEATH

99. MANNER OF DEATH

100. SIGNATURE OF PHYSICIAN

101. SIGNATURE OF WITNESS

102. SIGNATURE OF DECEASED

BUREAU V. 8

FEB 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1181

## CERTIFICATE OF DEATH

Dr Kneisley 01189

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash/ County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ORANGE</u> Middle <u>JUDD</u> Last <u>WYAND</u>				4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24 1876</u>	
9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Aaron C. Wyand</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Easterday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joseph J. Wyand Boston Mass</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the liver</u> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Not determined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct. 22</u> , 19 <u>56</u> , to <u>Jan. 21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 20</u> , 19 <u>57</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>				DATE SIGNED <u>1/22/57</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				ADDRESS (Street, city or town, state) <u>148 West Washington St. Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Jan. 24 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wesley Bowers</u>	

# CERTIFICATE OF DEATH

WARTLAND STATE DEPARTMENT OF HEALTH - BUREAU V. 2

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 Main St.		Farmer		Heart Disease		Natural		Jan 28, 1957		New York	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		High School		Methodist	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
Jan 28, 1957		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

JAN 28 1957

RECEIVED